

Exhibit B

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

B.P.J. by her next friend and)
mother, HEATHER JACKSON,)

)
)
Plaintiff,)
)

vs.)

No. 2:21-cv-00316
)

WEST VIRGINIA STATE BOARD OF)
EDUCATION, HARRISON COUNTY)
BOARD OF EDUCATION, WEST)
VIRGINIA SECONDARY SCHOOL)
ACTIVITIES COMMISSION, W.)
CLAYTON BURCH in his official)
capacity as State)
Superintendent, DORA STUTLER,)
in her official capacity as)
Harrison County)
Superintendent, and THE STATE)
OF WEST VIRGINIA,)

)
)
Defendants,)
)

LAINIEY ARMISTEAD,)
)

)
Defendant-Intervenor.)
)
-----)

VIDEOTAPED DEPOSITION OF
STEPHEN LEVINE
Wednesday, March 30, 2022
Volume I

Reported by:
ALEXIS KAGAY
CSR No. 13795
Job No. 5122884
PAGES 1 - 289

IN THE UNITED STATES DISTRICT COURT
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CHARLESTON DIVISION

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Plaintiff,

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EDUCATION, HARRISON COUNTY
BOARD OF EDUCATION, WEST
VIRGINIA SECONDARY SCHOOL
ACTIVITIES COMMISSION, W.
CLAYTON BURCH in his official
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in her official capacity as
Harrison County
Superintendent, and THE STATE
OF WEST VIRGINIA,

Defendants,

LAINIEY ARMISTEAD,

Defendant-Intervenor.

Remote videotaped deposition of
STEPHEN LEVINE, Volume I, taken on behalf of Plaintiff,
with all participants appearing remotely, beginning at
9:09 a.m. and ending at 5:46 p.m. on Wednesday,
March 30, 2022, before ALEXIS KAGAY, Certified
Shorthand Reporter No. 13795.

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18 Videographer:

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WITNESS

EXAMINATION

STEPHEN LEVINE

Volume I

BY MS. HARTNETT

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Exhibit 104 Video Clip 278

Exhibit 105 Video Clip 279

1 Wednesday, March 30, 2022

2 9:09 a.m. A.M.

3 THE VIDEOGRAPHER: We are on the record at
4 9:09 a.m. on March the 30th of 2022.

5 All participants are attending remotely. 06:09:27

6 Audio and video recording will continue to
7 take place unless all parties agree to go off the
8 record.

9 This is media unit 1 of the recorded
10 deposition of Dr. Stephen Levine, taken by counsel for 06:09:39
11 the plaintiff, in the matter of B.P.J., by her be- --
12 by her next friend and mother, Heather Jackson, versus
13 West Virginia State Board of Education, filed in the
14 U.S. District Court, for the Southern District of
15 West Virginia, Charleston Division, Case 06:09:59
16 Number 2:21-cv-00316.

17 My name is Kimberlee Decker from Veritext
18 Legal Solutions, and I am the videographer. The court
19 reporter is Alexis Kagay.

20 I am not related to any party in this action, 06:10:16
21 nor am I financially interested in the outcome.

22 Counsel and all present will now state your
23 appearances and affiliations for the record. If there
24 are any objections to proceeding, please state them at
25 the time of your appearance, beginning with the 06:10:31

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1 noticing attorney.

2 MS. HARTNETT: Good morning. I am Kathleen
3 Hartnett from Cooley, LLP, and I represent the
4 plaintiff B.P.J.

5 I will let my co-counsel introduce themselves, 06:10:40
6 starting with my colleagues at Cooley.

7 MR. BARR: Good morning. Andrew Barr from
8 Cooley, LLP, for the plaintiff.

9 MS. VEROFF: Good morning. This is Julie
10 Veroff from Cooley, LLP, for Plaintiff. 06:10:53

11 MS. KANG: Good morning. This is Katelyn Kang
12 from Cooley, LLP, for Plaintiff.

13 MS. PELET DEL TORO: Good morning. This is
14 Valeria Pelet del Toro of Cooley, for Plaintiff.

15 MS. REINHARDT: Good morning. This is 06:11:00
16 Elizabeth Reinhardt at Cooley, for Plaintiff.

17 MS. HELSTROM: Hello. This is Zoe Helstrom
18 from Cooley, LLP, for Plaintiff.

19 COUNSEL SWAMINATHAN: Good morning. This is
20 Sruti Swaminathan from Lambda Legal, for Plaintiff. 06:11:26
21 And I have a paralegal at Lambda, Maia Zelkind, with me
22 as well.

23 MR. BLOCK: Good morning. This is Josh Block
24 from the ACLU, for Plaintiff.

25 MS. DENIKER: Good morning. Susan Deniker 06:11:44

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1 from Steptoe & Johnson, PLLC, representing Harrison
2 County Board of Education and Superintendent Dora
3 Stutler.

4 MS. MORGAN: This is Kelly Morgan on behalf of
5 the West Virginia Board of Education and 06:11:58
6 Superintendent Burch.

7 MS. ROGERS: This is Shannon Rogers on behalf
8 of the West Virginia Secondary School Activities
9 Commission.

10 MR. TRYON: This is David Tryon. I'm with the 06:12:12
11 West Virginia attorney general's office, representing
12 the State of West Virginia.

13 MR. BROOKS: This is Roger Brooks with
14 Alliance Defending Freedom, representing the intervenor
15 Lainey Armistead and defending Dr. Levine today in this 06:12:28
16 deposition. With me is my colleague and law clerk,
17 Lawrence Wilkinson.

18 THE VIDEOGRAPHER: Thank you.

19 Will the court reporter please swear in the
20 witness. 06:12:41

21
22 STEPHEN LEVINE,
23 having been administered an oath, was examined and
24 testified as follows:
25

EXAMINATION

BY MS. HARTNETT:

Q Good morning, Dr. Levine.

A Good morning.

MS. HARTNETT: Before we start, I'm just going 06:13:01
to put a housekeeping matter on the record that the
attorneys discussed before we went on the record and
that is that objection to form preserves all objections
other than privilege and that the parties will make an
effort to use "form," "scope" and "terminology" as the 06:13:13
shorthand objections. In addition, an objection by one
defendant is an objection for all defendants.

Could any counsel for the defense let me know
if they have any disagreement with that?

MR. BROOKS: We have agreed, in fact. 06:13:30

MS. HARTNETT: Thank you very much.

BY MS. HARTNETT:

Q So again, my name is Kathleen Hartnett, and
I'm with the law firm called Cooley, LLP.

Can you hear me okay? 06:13:41

A I do. At this point, yes.

Q Okay. Please let me know if that changes.

I use she/her pronouns.

Would you please state and spell your name for
the record. 06:13:53

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1 A Stephen Barrett Levine, S-T-E-P-H-E-N

2 B-A-R-R-E-T-T L-E-V-I-N-E.

3 Q And what pronouns do you use?

4 A He/him.

5 Q Thank you. Dr. Levine, you've been deposed 06:14:07
6 many times before; correct?

7 A Yes.

8 Q Was the most recent deposition that you gave
9 in September of last year, 2021?

10 A No. 06:14:21

11 Q What was the most recent deposition that you
12 gave?

13 A In -- within the last month, I was deposed in
14 a Connectica- -- a Connecticut case involving a
15 transgender prisoner. 06:14:41

16 Q Do you know the name of that case?

17 A Probably Clark versus the department of
18 corrections in Connecticut. Connecticut Department of
19 Corrections (sic).

20 Q Okay. And what was your -- the nature of your 06:15:01
21 testimony in that Connecticut case, this recent
22 deposition that you gave?

23 A Well, I provided a psychiatric evaluation of
24 the patient and made recommendations. It -- it was --
25 I'm hesitating because -- I provided a thorough 06:15:28

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1 psychiatric evaluation of the developmental history and
2 the in prison history of the patient and the -- the
3 psychology of his new transgender identity.

4 Q And you say "new transgender identity."

5 Was the new identity of -- male or female? 06:16:02

6 A The -- the new identity as a transgender
7 woman.

8 MR. BROOKS: And -- and, Counsel, I will
9 caution that obviously any detail about a psychiatric
10 evaluation of an individual prisoner is a matter 06:16:18
11 covered by confidentiality that Dr. Levine is not free
12 to get into detail about.

13 MS. HARTNETT: I hear you. I -- this is not a
14 disclosed matter on his CV and is a recent deposition,
15 so we'll have to just determine whether we need more 09:16:23
16 information, but thank you.

17 BY MS. HARTNETT:

18 Q Could you let me know what -- without giving
19 any personal identifying -- or, I guess, any more
20 detail than you believe appropriate, could you tell me 09:16:33
21 what the nature of any recommendations you made were in
22 that matter?

23 A My recommendations were to provide a pathway
24 towards further evaluation so that eventually a
25 decision could be made about whether sex reassignment 09:16:56

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1 surgery would be appropriate.

2 The -- the reason I'm hesitating is that that
3 really did not come to be the subject of the
4 deposition. The subject of the deposition really was
5 the contents of my evaluation, which was done two years 09:17:24
6 before, and -- so lots of things had happened in the
7 two years since I saw the patient or interviewed the
8 patient and -- so I was not able to make
9 recommendations based on current knowledge of the
10 patient, and so I did not. 09:17:43

11 Q And was the -- prior to this recent deposition
12 in Clark, was the most recent deposition before that
13 the deposition in September of last year?

14 A Yes.

15 Q Thank you. And I'm asking that by way of 09:18:03
16 introduction just because I want to make sure we're on
17 the same page about the ground rules for the
18 deposition, and it sounds like you've been through this
19 before, but I'll just let you know my basic ground
20 rules and make sure we're on the same page. 09:18:18

21 So I will ask questions, and you must answer
22 the questions unless your counsel instructs you not to
23 answer.

24 Do you understand that?

25 A I do. 09:18:26

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1 Q And if your counsel objects, you'll still need
2 to answer my question unless you've been instructed not
3 to answer.

4 Do you understand that?

5 A I do. 09:18:35

6 Q If you don't answer (sic) my question, could
7 you please let me know, and I'll be happy to try to
8 rephrase it or make it clear for you?

9 Does that make sense?

10 A I'll try to remember. 09:18:48

11 Q And if you answer, I will assume you
12 understood the question.

13 Do you understand that?

14 A Yes.

15 Q I'm going to try -- try to take a break every 09:19:00
16 hour or so. If you need a break at a different time,
17 please let me know.

18 Do you understand that?

19 A I understand.

20 Q And if I've asked a question, you'll need to 09:19:11
21 provide an answer before we take a break.

22 Do you also understand that?

23 A I do.

24 Q I will do my best not to speak over you -- and
25 please use verbal answers so the court reporter can 09:19:25

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1 transcribe your answers. Nodding or shaking your head
2 can't be captured on the transcript.

3 Do you understand that?

4 A I do, but I can guarantee you you'll have to
5 remind me of that. 09:19:36

6 Q Well, you may have to do the same for me, but
7 we'll try.

8 I also just want to explain what I'm going to
9 mean when I use a couple of terms today.

10 For purposes of this deposition, when I say 09:19:51
11 "cisgender," I will mean someone who's gender identity
12 matches the sex that was recorded for that person at
13 birth.

14 Do you understand that?

15 A Yes. 09:20:02

16 Q And then when I say the word "transgender," I
17 will mean someone whose gender identity does not match
18 the sex for which was recorded at birth.

19 Do you understand that?

20 A Yes. 09:20:13

21 Q And when I say "B.P.J.," I'm referring to the
22 plaintiff in this case.

23 Do you understand that?

24 A Yes.

25 Q Do you understand that you are testifying 09:20:21

1 under oath today just as if you were testifying in
2 court?

3 A Yes.

4 Q Is there anything that would prevent you from
5 testifying truthfully today? 09:20:32

6 A No.

7 Q Are you taking any medication that would
8 affect your ability to give truthful testimony?

9 A Well, I took a sleeping pill last night, but I
10 feel reasonably alert today. 09:20:48

11 Q Okay. So you don't -- you don't have a belief
12 that that medication you took last night will affect
13 your ability to give truthful testimony today?

14 A I -- I don't think it will.

15 Q Do you know what case you're being deposed in 09:21:06
16 today?

17 A Well, I -- yes.

18 Q What case is that?

19 A B.P.J. versus Department of Education.

20 Q And do you know what jurisdiction this case is 09:21:19
21 from?

22 A West Virginia.

23 Q And do you have -- sorry.

24 Do you have an understanding of the issue
25 presented by this case? 09:21:35

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1 A I have an understanding. I'm not sure it is
2 the correct understanding, but I do have an
3 understanding.

4 Q Understood. What is your understanding of
5 this case? 09:21:47

6 A The plaintiff and next friend and mother wish
7 the young person to be able to compete in athletics
8 according to their current gender identity and
9 apparently the State Board of Education is --
10 disagrees. 09:22:13

11 Q Okay. Thank you.

12 So we already touched on that you had been
13 deposed previously. I just want to ask you about a
14 couple of specific depositions you gave to see if you
15 recall those? 09:22:29

16 There was a matter in North Carolina called
17 Kadel that you gave a deposition in September of 2021
18 regarding state employee healthcare.

19 Do you recall giving that deposition?

20 A Would you repeat -- regarding what? I didn't 09:22:41
21 hear that last phrase.

22 Q I'll try to speak more slowly.

23 That was regarding -- so let me just start
24 that one again.

25 So do you recall giving a deposition in a 09:22:51

1 North Carolina matter called Kadel in September of 2021
2 regarding state employee healthcare?

3 A Yes.

4 Q Do you recall giving a deposition in a Florida
5 case in December of 2020 called "Claire"? That was 09:23:07
6 also about state employee healthcare.

7 A Yes.

8 Q There also was a case called Keohane in
9 Florida where you gave a deposition in 2017 and that
10 was a prisoner case. 09:23:21

11 Do you recall that?

12 A Yes.

13 Q Did you give true and correct testimony in
14 those depositions?

15 A Yes. 09:23:31

16 Q Have you always given true and correct
17 testimony in your depositions?

18 A To the best of my knowledge, yes.

19 Q Thank you. And you've had depositions in
20 cases involving prisoners who were seeking care for 09:23:45
21 gender dysphoria; is that correct?

22 A Yes.

23 Q Have you ever testified in favor of a prisoner
24 who was seeking medical care for gender dysphoria?

25 A Yes. 09:23:59

1 Q Can you describe those instances where you've
2 testified in favor of a prisoner seeking medical care
3 for gender dysphoria?

4 A In the last case involving a prisoner by the
5 name of Soneeya, S-O-N-E-E-Y-A, I recommended transfer 09:24:14
6 to a female prisoner and -- sorry -- transfer to a
7 female prison and the opportunity to have sex
8 reassignment surgery if, after a year of adaptation
9 there, there were no significant decompensations or
10 problems. 09:24:44

11 Q And do you remember what year you made that
12 recommendation?

13 A I think it was 2019.

14 Q Okay. And can you -- are you aware of any
15 other examples of you having testified in favor of a 09:25:05
16 prisoner seeking medical care for gender dysphoria?

17 A I'm hesitating because medical care includes
18 many things. And so the answer is yes. It involves
19 accommodations to their current gender identity in
20 terms of canteen items, for example, and it includes 09:25:35
21 the prescription of cross gender -- cross-sex hormones.
22 So I've been involved in the provision of those kind of
23 things repeatedly over the years for prisoners.

24 Q Have you ever, other than in the Soneeya
25 matter, recommended that a prisoner -- sorry -- 09:26:04

1 testified that a prisoner should receive gender
2 confirmation surgery?

3 A I'm hesitating to answer the question because
4 it's about testimony. In my work as consultant, I have
5 repeatedly recommended both surgery and, more -- more 09:26:25
6 commonly, hormone treatment, electrolysis treatment,
7 canteen item treatment. Most of -- the vast majority
8 of these cases never come to trial.

9 Q When is the last time that you recommended
10 that a pres- -- a prisoner should have hormone 09:26:46
11 treatment?

12 A It would have been the third Thursday in
13 March, this year.

14 Q And where is that prisoner located?

15 A Massachusetts. 09:27:06

16 Q Can you estimate how many prisoners you've
17 given a recommendation about through the course of your
18 career?

19 A That would be very difficult. I've been the
20 consultant to the department of corrections gender 09:27:30
21 identity committee since, I think, 2008 and every month
22 since that time, with less than one handful of
23 exceptions, I've been present at discussions, and we've
24 recommended accommodations in prison to people who
25 declare identity as a trans woman. And I would say 09:27:58

1 probably, and I ask you not to hold me to this number,
2 40 times.

3 Q Sorry, 40 times describes what?

4 A That -- that I've joined a group of people who
5 decided to provide electrolysis, canteen item -- 09:28:25
6 special privileges for canteen items, that is, female
7 canteen items, the ability to shower alone, the ability
8 to be tapped down or searched by a female attendant,
9 not a male attendant, a correction officer, hormone --
10 the beginning of hormone treatment and -- and, of 09:28:52
11 course, bilateral mastectomies and -- and on several
12 occasions, male gender confirming surgery for biologic
13 males who are living as trans women. In other words,
14 the whole gamete of services.

15 Q So 40 times you've recommended something -- or 09:29:19
16 joined in a recommendation for something for -- a
17 prisoner to receive medical care, as you've broadly
18 described that term?

19 A Yes.

20 Q And then how many times can you estimate where 09:29:34
21 you had made a recommendation that the prisoner should
22 not receive medical care, as you've broadly defined it?

23 A I don't think I've ever recommended that no
24 treatment be offered to this person. The -- the --
25 because the treatment involves that entire array of 09:30:07

1 matters that I just delineated.

2 And so prisons -- or at least Massachusetts,
3 where I work as a consultant, has been very --
4 eventually, by 2008, has been -- have been very
5 interested in providing individual services to -- to 09:30:26
6 help these people diminish their pain about their
7 incongruence, and I have been one of the people who
8 devised the program.

9 Q The prisoner that you reco- -- you
10 recommended -- sorry -- that you were referring earlier 09:30:49
11 to, the one in the Clark matter, do you recall us
12 discussing that?

13 A I do.

14 Q And that person identifies as female; correct?

15 A Yes. 09:31:00

16 Q Do you view that person as a female?

17 A I view that person as a trans woman.

18 Q You have just testified that you've never
19 recommended that a -- no treatment be offered to a
20 prisoner for gender dysphoria; is that correct? 09:31:22

21 A I'm hesitating because "no treatment"
22 includes -- would include all of the above, of the
23 array I previously listed, and at this moment, I don't
24 recall ever saying no treatment should be given to this
25 individual, no accommodation should be given to this 09:31:47

1 individual.

2 Q Do you recall if you've ever recommended that
3 no surgery be permitted for an individual in prison?

4 A Oh, yes, I have. I have said that I didn't
5 think sex reassignment surgery -- in those days, that's 09:32:06
6 what we called it, but it's now called gender
7 confirming surgery -- I have said I did not think
8 sex -- that kind of surgery was indicated or
9 necessary -- medically necessary.

10 Q And so how many times did you say that surgery 09:32:26
11 was medically necessary?

12 A Would you repeat that, please.

13 Q How many times did you say that surgery was
14 medically necessary for a prisoner?

15 MR. BROOKS: Objection; ambiguous. 09:32:45

16 THE WITNESS: You may or may not know that I
17 do not like the term "medically necessary." I prefer
18 to use the term "would be psychologically beneficial to
19 this person." So that's the reason I'm hesitating
20 answering your question. 09:33:12

21 I generally avoid using the term "medical
22 necessity." Instead, I try to make a determination
23 whether I think, in the -- in the long run, this
24 particular intervention that we're talking about would
25 be psychologically beneficial to the patient. 09:33:29

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1 BY MS. HARTNETT:

2 Q My question is whether you've ever recommended
3 any gender confirming surgery as medically necessary
4 for a prisoner.

5 A Yes, I -- I have signed my name to such 09:33:47
6 documents, such recommendations, because where I work,
7 in Massachusetts, this is the way that the -- most of
8 the staff and -- and -- that -- that is the common term
9 used to -- to justify that kind of intervention.

10 Q How many times have you signed your name to 09:34:10
11 that kind of intervention for a prisoner?

12 A Perhaps five times.

13 Q And you referenced the Soneeya matter;
14 correct?

15 A Correct. 09:34:38

16 Q And years earlier than the 2019 recommendation
17 that you just described, you testified against surgery
18 for that prisoner; correct?

19 A That is not correct.

20 Q What's not correct about that? 09:34:50

21 A That I did not testify -- I did not testify
22 against sex reassignment surgery.

23 Q Did you testify against something earlier in
24 that matter?

25 A I testified the recommendation to -- to have 09:35:05

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1 what the judge called a soft landing, like first
2 transferring the person to a female facility, and then,
3 based upon her adaptation there, to have sex
4 reassignment surgery.

5 In fact, that was really -- the issue was not 09:35:29
6 whether the person should eventually have sex
7 reassignment surgery, but -- but whether it should be
8 done before transfer to the female facility or after
9 transfer.

10 Q Did that prisoner seek sex reassignment 09:35:46
11 surgery before transfer?

12 A Please repeat that.

13 Q Did that prisoner seek sex reassignment
14 surgery before transfer?

15 A She did until we presented this idea to her, 09:36:04
16 and she jumped at the idea. She thought it was a very
17 good idea when we interviewed her. And by the time
18 this case got to court, her attorneys were arguing for
19 immediate sex reassignment surgery. But --

20 Q So she -- by the time you were -- oh, pardon 09:36:27
21 me. Please complete your answer.

22 A So we were aware that, because we were in the
23 room when we -- I discussed this with her, she was very
24 happy with the idea of transfer with the -- because she
25 was very positive that she would have a fine adaptation 09:36:41

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1 among women prisoners, and she was delighted.

2 And then months later, when this came to
3 trial, the -- her attorney arg- -- was arguing against
4 that.

5 Q So you testified against her wishes as 09:37:05
6 expressed by her attorney at trial; correct?

7 A I never conceived that I was testifying
8 against Soneeya. You may do that, but I -- that's not
9 my concept.

10 Q In the cases where you've given testimony 09:37:24
11 about employee healthcare coverage, you were testifying
12 against the employee healthcare coverage for gender
13 dysphoria; correct?

14 A Incorrect.

15 Q What's incorrect about that? 09:37:38

16 A What I was testifying to is my understanding
17 of the state of science. I was not taking a stand that
18 people should not have healthcare coverage. I was
19 trying to inform the Court about what we knew about
20 this subject and what we don't know about this subject. 09:37:58

21 I didn't take a position that -- that I knew
22 what should be done. I was just here as a -- to offer
23 what I understood about the state of science, about
24 various aspects of surgical and medical and
25 psychological care for the trans population. 09:38:18

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1 Q Are you aware in the Kadel and the Claire
2 matters -- those are the North Carolina and Florida
3 employee healthcare coverage matters -- your testimony
4 was submitted by the defendants in that case against
5 the relief being sought? Are you aware of that? 09:38:37

6 A I was aware that -- who employed me and what
7 their purposes were, but -- but I was not enjoining
8 psychologically with the idea that I was doing anything
9 but offering the Court what I hope to be an objective
10 appraisal of the state of knowledge based upon 09:39:01
11 literature and, you know, participation in trans care
12 over the years.

13 Q So were you, in those two matters, agnostic as
14 to whether the employees received the healthcare
15 coverage or not? 09:39:21

16 A Agnostic?

17 Q That you didn't have a view.

18 A Would you -- would you mind explaining that
19 term? I'm -- I usually understand that in terms of
20 religious notions. 09:39:34

21 Q That you did not have a view -- in those
22 cases, Kadel and Claire, is it fair to say you did not
23 have a view as to whether the healthcare coverage
24 should be extended or not?

25 A I felt insufficient to make a societal 09:39:47

1 decision. I'm not an expert in the insurance industry
2 at all. I -- I am certainly not an expert in the
3 political processes in any particular state. The
4 only -- the only knowledge base that I feel I have
5 comes from the study of the literature and the 09:40:05
6 participation in trans care, both in the community and
7 in prison systems.

8 And so the fact that the State used my
9 testimony does not really equate, in my mind, with my
10 position on whether or not people should have 09:40:31
11 healthcare insurance.

12 I -- again, to repeat, my understanding is I
13 am somewhat knowledgeable about the state of science in
14 this area and that the various people on law -- on the
15 side of -- in -- in -- in judicial issues -- judicial 09:40:48
16 matter want somebody who can articulate the state of --
17 of knowledge. And that's what I do.

18 The state of knowledge should be applied, in
19 my view, to both sides of the issue, not just, you
20 know, the State or the Board of Education. It should 09:41:09
21 be -- it should be established -- it should be relevant
22 to the plaintiff's side.

23 Q Were you paid by the State in the
24 North Carolina and the Florida matters for your
25 testimony? 09:41:27

1 A Ultimately, I think I was paid by the State,
2 but the check did not come from the State. The check
3 came from the lawyer who employed me.

4 Q Understood. Have you ever provided testimony
5 with your -- what you've described as your expertise in 09:41:46
6 favor of -- on the side of extending the healthcare
7 coverage to tran- -- to people seeking care for gender
8 dysphoria?

9 A No attorney representing that side of the
10 issue has ever hired me, but if they would, I would be 09:42:03
11 happy to present my knowledge or -- to, and they can do
12 what they want with that testimony.

13 Q You were deposed in at least one child custody
14 matter in Texas where a child wanted to transition; is
15 that correct? 09:42:26

16 A I was.

17 Q And you testified in trial at that matter,
18 too?

19 A I did.

20 Q And was your testimony in that case in 09:42:37
21 opposition to the desired transition?

22 A The testimony in that case was to present the
23 state of knowledge about this matter. I did not take a
24 position that a child should or should not have a
25 particular treatment. I was just informing the Court, 09:42:56

1 as I previously described to you. I thought I was a
2 witness about the nature of knowledge about trans
3 children.

4 THE WITNESS: Could you get me some water,
5 please.

09:43:16

6 BY MS. HARTNETT:

7 Q Sorry, is your testimony that you, in that
8 case, in the -- this is the Younger matter; is that
9 correct?

10 A Yes. That's what I understand you to be
11 referring to.

09:43:23

12 Q And your testi- -- your testimony today is
13 that you were not testifying in opposition to the
14 transition that the child -- of the child in the
15 Younger matter?

09:43:36

16 A I was hired by the lawyer who was representing
17 the father who did not want his son to be transitioned
18 to a little girl, socially. But I was not testifying
19 that the child should not be transitioned. I was
20 testifying -- I had no knowledge of that -- I wasn't
21 asked for that question. That -- that was never asked
22 of me, Ms. Hartnett. What was asked of me was what we
23 knew about this subject. And, therefore, I felt
24 comfortable sharing the state of knowledge and -- and
25 what is missing from our knowledge.

09:44:02

09:44:23

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1 Again, it -- it has the appearance that I was
2 testifying against the socialization of the child, but
3 I think if you look closely at that, what I was doing
4 was telling the Court what was known and what was not
5 known and what the consequences were, the implications 09:44:45
6 of treating the child one way versus another.

7 Q So you did not testify in that matter that
8 desistance was preferable to affirmation?

9 A I actually don't recall if I made that
10 statement. It's -- I just don't recall. 09:45:09

11 Q Okay. Has your testimony -- oh, sorry.

12 Have you testified in any other matters of --
13 similar to the Younger matter, in which parents were
14 disputing the proper care of their child who sought
15 care for gender dysphoria? 09:45:37

16 A Yes. There was a case that I believe is
17 sealed in the Tucson court. I don't know if I'm
18 allowed to give the name. I presume I can give the
19 name. I don't know.

20 MR. BROOKS: If -- if it's sealed, I would not 09:45:56
21 give any identifying information.

22 THE WITNESS: But the answer to your question
23 is yes.

24 BY MS. HARTNETT:

25 Q And in that matter, did your -- was your 09:46:05

1 testimony used by the party who was opposing the
2 treatment for gender dysphoria for the child?

3 A In that particular matter, it was the parents,
4 who hired me, who objected to losing custody of their
5 child when the child was hospitalized for a suicide 09:46:38
6 gesture and told the people in the hospital that her
7 evil parents were preventing her, at age 13, from
8 transitioning to being a boy. And her parents --

9 MR. BROOKS: I'm just going to interrupt and
10 caution the witness. I'm not part of that case, but 09:47:03
11 I -- nor do I want Dr. Levine to violate any
12 confidentiality obligations.

13 So as you answer, whatever level of generality
14 you think is appropriate, just be very careful not to
15 disclose information that you believe you received in 09:47:18
16 confidence and that remains confidential given the
17 conduct of that case.

18 So I -- I don't want us in our proceedings to
19 violate any obligations of that proceeding.

20 THE WITNESS: Well, given that, I actually 09:47:35
21 think anything I would say about this would violate the
22 confidentiality rule here, and I think I've told you
23 enough about the case.

24 MS. HARTNETT: Well, I don't want to waste our
25 time on the record discussing this, but we have a right 09:47:51

1 to discovery into your testimony, so we will follow up
2 with counsel to figure how to get it.

3 BY MS. HARTNETT:

4 Q When was this testimony given?

5 A In the spring of 2021. And if I'm wrong, it 09:48:13
6 was in the spring of 2020.

7 Q Thank you. And, sorry, what -- was the
8 testimony given in deposition or trial or some other
9 fashion?

10 A In juvenile court. 09:48:32

11 Q In what form did the testimony take?

12 MR. BROOKS: Objection; vague.

13 BY MS. HARTNETT:

14 Q Just, sorry, meaning written or oral.

15 A Oh, in person? I was in -- I was in person by 09:48:50
16 video, and I was cross-examined, you know.

17 I also submitted a report of the psychiatric
18 evaluation.

19 Q Any other testimony that you've given in a
20 case involving parents and the potential care of a 09:49:13
21 child with gender dysphoria?

22 A I submitted a rebuttal to a report in a case
23 in Cincinnati I think the first week of January of this
24 year. The case is called Siefert, S-I-E-F-O-R-D (sic),
25 or E-R-T, something like that. Siefert versus Hamilton 09:49:49

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1 County, which is the Cincinnati county.

2 So that would be the answer to your question.

3 Q And what's the nature of that matter, the
4 Siefert matter?

5 A The -- the child, who was identifying as a 09:50:08
6 trans male, were treated -- the parents were treated
7 during the hospitalization as persona non grata and the
8 hospital refused to discharge the patient even though
9 the patient did not meet criteria for continued
10 hospitalization and -- so the -- the parents were 09:50:46
11 objecting to the loss of parental rights.

12 Subsequently, the child reidentified as a
13 female and -- so I don't know what the outcome has been
14 legally. It's in process.

15 And I just commented on the limitations of 09:51:07
16 the -- another expert who felt that it was justified to
17 keep the child in the hospital against the parents'
18 wishes, for two and a half months.

19 Q In the Tucson matter that you discussed,
20 which, again, we will follow up on, but can you just 09:51:34
21 tell me if that's been resolved? Do you know if that's
22 reached a conclusion?

23 A Yes, that -- the -- the particular judicial
24 issue was -- was resolved. Whether or not the parents
25 are going to continue to sue the -- the child welfare 09:51:56

1 organization, I -- I don't know. I haven't heard -- I
2 haven't had any follow-up on the case since it was
3 adjudi- -- since it was resolved.

4 Q Thank you. Has your testimony ever been
5 excluded by a court?

09:52:18

6 A Yes.

7 Q When?

8 A 2015.

9 Q What matter was that?

10 A It was in the matter of a prisoner named

09:52:33

11 Noseworthy (sic) in California.

12 Q And what is your understanding of how your
13 testimony was excluded?

14 A Well, I didn't actually have testimony. I

15 submitted a psychiatric evaluation and a

09:52:50

16 recommendation, and I was never invited to a -- a

17 courtroom for that.

18 The judge -- I presented, in my written

19 deposition, an account of a female prisoner who had a

20 very extremely negative outcome from genital surgery,

09:53:12

21 and the judge -- the judge thought I was lying about

22 this case, and he also did not think that -- that I

23 followed the Harry -- the WPATH standards of care, and

24 he dismissed my -- without asking me one question,

25 without asking me do I have any evidence to show that I

09:53:39

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1 wasn't lying about this case, he -- he dismissed my
2 recommendation.

3 So I'm aware that judges have their -- judges
4 can make mistakes. Because I, in fact, have in my
5 possession the case history, I saved the case history 09:54:01
6 that was presented to me by the California Department
7 of Corrections, and that -- no one seems to know that.
8 Or at least the judge did not inquire about that. I
9 never had a chance to defend myself and -- so that's --
10 that's when my testimony was dismissed. 09:54:24

11 Q Thank you. Is there any other time where your
12 testimony has been excluded by a court?

13 MR. BROOKS: Objection; vague.

14 THE WITNESS: Well, I believe that the impact
15 of that judge in the Noseworthy -- Norsworthy case has 09:54:48
16 influenced two other cases to discredit my position, at
17 least whatever I said on those other cases -- on one
18 other case.

19 One of the cases that -- that my name gets
20 brought up about, I actually never submitted any 09:55:10
21 testimony to, but someone quoted what I had taught in a
22 workshop; and, therefore, the judge dismissed that
23 testimony.

24 You should understand that since that time and
25 even before that time, my testimonies have been 09:55:29

1 accepted by various courts, and -- for example, in the
2 district court of Arizona, in a case involving
3 insurance coverage, the judge quoted my testimony.
4 That -- that was appealed to the Ninth Circuit Court,
5 and the Ninth Circuit Court made -- made a reference 09:55:49
6 to, but did not name my testimony.

7 And so it seems to me that since -- before
8 2015, in that particular case, and subsequent to 2015,
9 my testimony has been accepted by various courts, in
10 various matters involving, you know, trans issues that 09:56:10
11 I am asked to opine about.

12 Q Thank you. Is there any other example you can
13 think of where your testimony has been excluded by a
14 court?

15 MR. BROOKS: Objection, vague. 09:56:37

16 THE WITNESS: Well, I'm aware of the
17 Noseworthy case, the -- the Edmo case, and there's a
18 Hecox case.

19 But again, all these exclusions were
20 objections to my expertise derived from the judge in 09:56:58
21 the Norsworthy case.

22 And the answer to your specific question, I am
23 not aware of any other situation where my testimony was
24 excluded.

25 Q Thank you. For the Noseworthy case, you did 09:57:13

1 submit an expert report; correct?

2 A I -- I -- yes.

3 Q So you understand this case involves sports;
4 correct?

5 A Yes. 09:57:42

6 Q What, if any, prior testimony have you given,
7 whether by declaration or report or oral testimony,
8 about transgender participation in sports?

9 A I believe that both in the Connecticut case
10 and in the Hecox case the expert opinion report that I 09:58:09
11 gave about the state of knowledge in this field has
12 been submitted for the Court's consideration.

13 I am not an expert, as you probably know, in
14 matters of athletics and physiology. I am only
15 providing information that I feel I know about, which 09:58:41
16 is the knowledge and the lack thereof about certain
17 issues related to trans care.

18 So I -- I've never really, as far as I know,
19 as far as I remember, made an opinion about this should
20 happen or this should not happen. I'm just providing 09:59:06
21 information to the courts about what I know and what is
22 not known by society or by science.

23 Q Thank you. So in this case, for example,
24 B.P.J., is it fair to say you do not have an opinion as
25 to whether she should be permitted to play sports? 09:59:25

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1 A I do not have an opinion.

2 Q Have you -- setting aside the context of
3 transgender participation in sports, have you ever
4 given any testimony of any kind in a matter related to
5 sports? 09:59:51

6 A I can't think of any.

7 Q Have you given any prior testimony, whether by
8 declaration, report or oral testimony, about
9 prepubertal trans- -- transgender children?

10 MR. BROOKS: Let -- let me ask you to restate 10:00:16
11 that question. Not to rephrase it, necessarily. I
12 just want to hear it back.

13 MS. HARTNETT: Sure.

14 BY MS. HARTNETT:

15 Q Have you given any prior testimony by 10:00:22
16 declaration, report or oral testimony involving
17 prepubertal transgender children?

18 A I'm hesitating because I have written about
19 informed consent and -- and that my writings about
20 informed consent have covered all trans, beginning with 10:01:02
21 prebu -- prepubertal children. But your question is
22 about giving testimony about that. I would imagine
23 that in the Younger I may have raised the issue of --
24 of what we know -- I mean, I did raise tissue of what
25 was known and what is not known. 10:01:38

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1 So I would imagine the answer to your question
2 must be yes.

3 And the Arizona case that is sealed is not
4 about a preber -- prepubertal child. But, of course,
5 in taking a history of any child in adolescence, we 10:01:55
6 certainly take histories of their prepubertal period
7 and the behaviors evidenced during that time.

8 So I just find the answer to your -- I'm not
9 actually sure what the answer to your question should
10 be. 10:02:13

11 Q Did the Younger case involve a prepubertal
12 child?

13	A	It did.
----	---	---------

14 Q And the Arizona case did not involve a

15 preber -- prepubertal child; is that correct? 10:02:26

16 A That's -- that's correct.

17 Q And how about the Cincinnati case you
18 mentioned, was that a prepubertal child?

19	A	No.
----	---	-----

20 Q Can you think of any other -- and I'm setting 10:02:34
21 aside your nonjudicial work, but any -- any
22 testimony -- and I -- that was my question. Thank you
23 for focusing on that -- but any testimony you've given
24 other than these examples that you consider to be
25 related to prepubertal transgender children? 10:02:57

1 A The key word to your question is "testimony."
2 And so I have played -- I have -- I have offered
3 opinions to lawyers that never rose to the point of
4 testimony. So the --

5 Q And let me be clear. 10:03:25

6 A The answer to your question must be no.

7 Q And for this question, I was just trying to be
8 clear when I said "testimony," whether by written
9 declaration, written report or oral testimony.

10 And so I want to -- just using that 10:03:41
11 understanding of "testimony" for this question, other
12 than the Younger case, have you given any prior
13 testimony regarding a prepubertal -- in a case
14 involving a prepubertal transgender child?

15 A I'm trying to be helpful and -- and 10:03:55
16 informative to your question.

17 I think the -- I think the -- the -- to the
18 best of my knowledge, the answer is no, but people use
19 my knowledge, in my previous publications, and call me
20 sometimes and ask me opinions about matters -- the 10:04:24
21 lawyers, I mean, or guardian ad litem persons -- and --
22 but it's not testimony per se. I guess it would be
23 consultation.

24 Q Thank you. And then just again sticking with
25 testimony, which for this question I'm meaning to be 10:04:52

1 written or oral testimony in a judicial proceeding,
2 have you given any testimony about a case involving a
3 transgender adolescent, other than the Arizona case and
4 the Cincinnati case?

5 A At the moment, I can't think of any. 10:05:21

6 Q And have you -- and this is, again, for the
7 purposes of this questions meaning -- "testimony" to
8 mean written or oral testimony in a judicial
9 proceeding. Have you ever given testimony in support
10 of a transgender party? 10:05:40

11 A In support of a transgender what?

12 Q Party.

13 A Party. Please repeat that question.

14 MS. HARTNETT: Could the reporter read that
15 back. I'm not sure I could do it. 10:05:50

16 (Record read.)

17 THE WITNESS: I guess the key word in your
18 question is "support." And I want you to know that
19 when I testify about the state of knowledge, I actually
20 think that because my perspective is a long-term life 10:06:48
21 cycle perspective, I think of that my knowledge base
22 sometimes suggests that I'm actually being quite
23 supportive in -- in trying to have people understand
24 what the consequences of -- of, quote, affirmative or
25 supportive care actually may mean, what the risks are. 10:07:11

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1 So I believe your understanding of the word
2 "support" is different than my understanding of the
3 word "support."

4 But once again, I want to repeat, I
5 conceptualize what I'm doing is accurately stating the 10:07:32
6 state of science, of what is known, what is not known
7 and what we need to do in order to get the answers to
8 the unknown questions. That's what I'm doing.

9 I'm not supporting this or supporting that.
10 I'm not against this. I'm not against that. I'm 10:07:52
11 trying to give an appraisal of what we know, in a
12 scientific sense. Because of the one principles of
13 medical ethics is that science should lead our
14 therapeutics.

15 BY MS. HARTNETT: 10:08:07

16 Q Dr. Levine, you understand that your testimony
17 in this matter has been provided by the State, the
18 defendants, in support of their position; is that
19 correct?

20 A Yes. 10:08:15

21 Q And so when I use the word "in support of," in
22 the context of a judicial proceeding, you understand
23 that your testimony, what has been submitted in these
24 proceedings, is submitted in support of one party or in
25 support of another party; correct? 10:08:36

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1 A Yes. But that has to do with legal processes.
2 What -- what I am supporting is to inform the court of
3 what is known and what is not known. If you were to
4 hire me to tell what -- the Court what is known and not
5 known, I think I would be giving the same testimony. 10:08:58

6 Q Let me ask you again, then. Which of -- have
7 you ever previously given written or oral testimony
8 that was submitted in support of the transgender party
9 in a judicial proceeding?

10 MR. BROOKS: Objection. 10:09:16

11 THE WITNESS: You asked that question before,
12 so I'm going to answer it in the same way I answered it
13 before. It depends on your notion or my notion of
14 "support."

15 BY MS. HARTNETT: 10:09:36

16 Q I'm using the notion of "support" that we just
17 discussed, which is -- like, for example, your
18 testimony in this matter is being submitted in support
19 of the defendants. You understand that?

20 A I do. 10:09:44

21 MS. DENIKER: This is Susan Deniker. I just
22 want to place on the record an objection to the form.

23 BY MS. HARTNETT:

24 Q And using that understanding of "support," do
25 you agree with me that you have not previously had your 10:10:00

1 testimony submitted in a judicial proceeding in support
2 of the transgender party; correct?

3 MR. BROOKS: Objection.

4 THE WITNESS: Incorrect. I already told you
5 that I have recommended transfer to a female prison and 10:10:10
6 ultimate sex reassignment surgery and that -- for --
7 for the Soneeya case, and there were -- there was
8 another case -- another prisoner at the same time that
9 we made the same recommendation for.

10 And I've already told you that I have -- I -- 10:10:33
11 I -- I have participated in the support of -- of
12 bilateral mastectomies for female prisoners, but
13 that -- none of those cases have gone to court. So
14 I -- I guess that's not relevant to your question.

15 BY MS. HARTNETT: 10:10:51

16 Q Right. I was asking about whether you've
17 submitted, in a judicial proceeding, an opinion on the
18 side of the transgender party. Have you?

19 MR. BROOKS: Objection.

20 THE WITNESS: I already answered that question 10:11:10
21 three times about Soneeya.

22 BY MS. HARTNETT:

23 Q Can you please answer my question?

24 Have you ever submitted an expert opinion on
25 the side of the transgender party? 10:11:20

1 MR. BROOKS: Objection.

2 THE WITNESS: In your narrative --

3 BY MS. HARTNETT:

4 Q In a --

5 A In your -- 10:11:32

6 Q Sorry, I'm just trying to be really clear
7 since I understand you're disputing the term "support,"
8 which I thought was clear, but I -- I -- I'm listening
9 to you, and now I'm asking you whether, in a judicial
10 proceeding, you've ever submitted testimony on the side 10:11:43
11 of the transgender person, the formal side of the case.

12 MR. BROOKS: Objection. Experts don't
13 themselves submit anything in court.

14 You may answer, if you recall.

15 THE WITNESS: I may answer? 10:12:09

16 MR. BROOKS: If you recall.

17 THE WITNESS: I -- I find myself unable to
18 answer that question.

19 MS. HARTNETT: Okay. I'm going to introduce
20 an exhibit now, so we'll see how this Exhibit Share 10:12:22
21 works for you. Just a moment here.

22 MR. BROOKS: Tell me when you've placed it in
23 the folder, and I will then refresh the folder --

24 MS. HARTNETT: Will do.

25 We're starting with 86. Okay. Just one 10:12:49

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1 moment, please.

2 (Exhibit 86 was marked for identification
3 by the court reporter and is attached hereto.)

4 MR. BROOKS: Are you doing all right, or do
5 you want to take a break? 10:13:02

6 THE WITNESS: Well, she said we would have a
7 break in an hour. It's a little over an hour.

8 MR. BROOKS: If you're -- you're about to
9 introduce a document and you're taking a little time to
10 get that straight, let's take a short break. 10:13:07

11 MS. HARTNETT: That works for me. Thank you.

12 MR. BROOKS: All right.

13 THE VIDEOGRAPHER: We're off the record at
14 10:13 a.m.

15 (Recess.) 10:22:57

16 THE VIDEOGRAPHER: We are on the record at
17 10:23 a.m.

18 BY MS. HARTNETT:

19 Q Now, Dr. Levine, you've been retained as an
20 expert witness in this case, B.P.J.; correct? 10:23:20

21 A Correct.

22 Q Who retained you?

23 A Initially, David Tryon.

24 Q And was there someone who retained you after
25 that? 10:23:37

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1 A I -- I think David Tryon, in the matter and
2 means that I don't understand, created a liaison with
3 Alliance for Defending Freedom, Mr. Brooks, and then
4 they became -- so then I am -- I've been recruited by
5 both Mr. Tryon and Mr. Brooks, their -- their 10:24:10
6 particular institutions.

7 Q And with respect to Mr. Brooks, he's
8 affiliated with the Alliance for Defending Freedom, is
9 that your understanding?

10	A Yes.	10:24:29
----	--------	----------

11 Q Have you previously worked with the Alliance
12 for Defending Freedom on any matter?

13 A Yes. I -- I think of it as working with
14 Mr. Brooks.

15	Q And I don't want to --	10:24:45
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16 A Mr. Brooks is associated with the Alliance for
17 Defending Freedom, so I guess the answer to your
18 question is yes.

19	Q	When did you first work with Mr. Brooks?
----	---	------------------------------------------

20 A In the Young -- Young -- in the Younger case. 10:24:57

21 Q And that was the Texas matter we discussed?

22	A Yes.
----	--------

23 Q And I think you testified in your deposition
24 in the Claire matter, that's the Florida case, that you
25 worked with a lawyer from the Alliance Defending 10:25:17

1 Freedom to write your report in Younger; is that right?

2 A In -- the question is a little confusing to me
3 because you brought up the Florida case, and I don't --
4 could you repeat the question and ask me just one
5 question? 10:25:36

6 Q Sure. I was trying to orient you that I
7 understand that you gave a deposition in that Florida
8 matter of Claire; correct?

9 A I did.

10 Q And in that case, you were asked some 10:25:44
11 questions about your report. Do you remember that?

12 A You mean my report in the Younger case?

13 Q Correct.

14 A I don't remember that. I'm not denying it,
15 but I just don't remember that. 10:26:00

16 Q Yeah, was just curious about the kind of
17 genesis of your report in this case, and so what -- I
18 guess what I'll ask you is, is it -- is it fair to say
19 that you worked with a lawyer from the Alliance for
20 Defending Freedom to prepare your report in the Younger 10:26:14
21 matter? Correct?

22 A Yes.

23 Q And then your report in the Claire matter in
24 Florida was derivative of the Younger report; correct?

25 A I don't think that's correct. 10:26:27

1 Q What's not correct about it?

2 A I think the Florida case was about three --
3 the plaintiffs, I think, were three adults. The
4 Younger case was about, as we established before, a
5 very young child. 10:26:53

6 Q Okay. So your testimony is that the report
7 you submitted in the Claire case was not a derivative
8 of the report that was submitted in Younger; is that
9 right?

10 MR. BROOKS: Object to the form. 10:27:06

11 THE WITNESS: It's -- it's very difficult for
12 a person like me to know how my clinical activities and
13 my consulting activities interplay and influence one
14 another.

15 I am a very busy person, doing a lot of 10:27:28
16 different things, and I often think about, in a very
17 pleasing way, how my various activities cross-fertilize
18 my -- and stimulate my views, and what I read in one
19 case for one particular matter may stay with me and
20 help me understand yet another matter. 10:27:48

21 So this cross-fertilization is a very
22 intellectually stimulating process, but it makes me
23 very unable to answer the question about what
24 influenced what. You know, sometimes I read a novel
25 and it influences, I think. 10:28:08

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1 But it's hard -- I -- I can't really track,
2 with any degree of certainty, what influences what.

3 Perhaps if you had specific -- more specific
4 questions, I may be able to give you an opinion. But
5 based on what you just said, I -- I -- I'm at a loss to 10:28:29
6 answer it definitively.

7 BY MS. HARTNETT:

8 Q So I think my -- just to be clear for the
9 record, then, you cannot answer definitively whether
10 the report you submitted in the Claire case was a 10:28:44
11 derivative of the report that was done in the Younger
12 case; is that fair?

13 MR. BROOKS: Objection; vague.

14 THE WITNESS: Based on how I currently think
15 at the moment, I think it's correct. 10:28:59

16 BY MS. HARTNETT:

17 Q Sorry, correct that you -- you can't take a
18 view on that?

19 A It is correct that I don't know whether the
20 Younger case influenced my -- a specific -- I mean, 10:29:18
21 I -- I probably wrote many, many pages for the Florida
22 case, and so, you know, maybe there's a sentence or a
23 paragraph or two that, in my mind, was conceptualized
24 in part because of -- of my experience in the Younger
25 case. 10:29:38

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1 But at this moment, I cannot tell you
2 definitively this influenced me or this did not
3 influence me.

4 Number one, that was a couple of years ago.
5 Lots of things have happened in my brain in the last 10:29:51
6 couple of years.

7 Q Did any novels affect your expert opinion in
8 this case?

9 A Not that I can think of.

10 Q You mentioned that you first encountered 10:30:03
11 Mr. Brooks on behalf of ADF in the Younger case.

12 Can you tell me how you got connected with him
13 in that matter?

14 A He called me. He had read two papers, I
15 believe, that I had published, and he wanted to talk to 10:30:22
16 me.

17 Q So for this case, B.P.J., what were you asked
18 to do in terms of presenting an expert opinion?

19 A He wanted me to present the state of
20 knowledge, what is known and what is not known, about 10:30:47
21 trans care as a background for this particular case.
22 But he was aware, and -- and I told him very clearly --
23 that he was quite aware. I didn't have to tell him. I
24 just reminded him that I am not an expert in the
25 physiology of estrogen and testosterone blockages for 10:31:11

1 athletic capacities, I'm not an expert in lung volumes
2 and cardiac capacities. And -- and I asked him why --
3 why he would --

4 MR. BROOKS: I'm going to instruct you not to
5 disclose the substance of conversations with your 10:31:28
6 attorneys.

7 THE WITNESS: All right. Thank you.

8 BY MS. HARTNETT:

9 Q Was that a conversation you had before you
10 were retained in this matter, Dr. Levine? 10:31:36

11 A Was that a conversation?

12 MR. BROOKS: Counsel, the -- the witness can
13 answer that question, but any conversations surrounding
14 the retention, I will instruct the witness not to
15 answer. 10:31:53

16 THE WITNESS: I wondered why he needed my
17 testimony in this case. He provided an answer for me.

18 BY MS. HARTNETT:

19 Q Do you view your testimony as relevant to this
20 case? 10:32:07

21 MR. BROOKS: Objection.

22 THE WITNESS: Insofar as you make claims --
23 you -- that your side may make claims that is not --
24 that are not scientifically correct or established, it
25 may very well be relevant. 10:32:29

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1 But that is not a question for me to decide.

2 That's a question for lawyers on both sides and for the
3 judge.

4 Again, I'm just -- I'm just -- I just have a
5 certain limited understanding and knowledge which I 10:32:44
6 believe the Court might benefit from having.

7 BY MS. HARTNETT:

8 Q Did you prepare for the deposition today?

9 A Yes.

10 Q What did you do to prepare? 10:33:03

11 And please don't disclose your
12 communications that you had -- the substance of the
13 communications that you had with counsel.

14 A I reread my report Sunday evening. I met with
15 counsel yesterday afternoon. 10:33:17

16 Q How long did you meet for yesterday afternoon?

17 A I'm sorry, how long, did you say?

18 Q Yes, how long did you meet with counsel
19 yesterday afternoon?

20 A Between 1:30 and quarter to 7:00. 10:33:30

21 Q Did you review any documents to prepare for
22 this deposition other than your expert report?

23 MR. BROOKS: And you -- you can answer that
24 question yes or no without identifying specific
25 documents. 10:33:44

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1 THE WITNESS: Yes.

2 BY MS. HARTNETT:

3 Q Did you review the rebuttal report of
4 Dr. Safer?

5 MR. BROOKS: I'm going to instruct the witness 10:33:52
6 not to answer questions about what specifically he
7 reviewed with counsel yesterday.

8 MS. HARTNETT: I believe I have a right to
9 know what, if any, additional documents he's reviewed
10 before the deposition other than his report. 10:34:08

11 MR. BROOKS: On the contrary. I believe that
12 selection is my work product. And I stand by my
13 instruction.

14 BY MS. HARTNETT:

15 Q Outside the presence of your counsel, is there 10:34:15
16 anything other than the expert report that you reviewed
17 to -- before your deposition?

18 MR. BROOKS: On your own, outside our session
19 yesterday, did you review anything else in preparation
20 for your deposition? 10:34:32

21 THE WITNESS: No.

22 BY MS. HARTNETT:

23 Q Do any materials other than those cited in
24 your expert report inform your opinion in this matter?

25 MR. BROOKS: Objection. 10:34:49

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1 THE WITNESS: As was -- if you have read my
2 curriculum vitae, I have recently published two papers
3 about issues. One is titled the Reflections of a
4 Clinician about the trans -- the care of trans youth
5 that was published in November, in the Archives of 10:35:19
6 Sexual Behavior. And about 16 days ago, a new article
7 appeared online about informed consent, Reconsidering
8 Informed Consent in the Treatment of Trans Children,
9 Adolescents, and Young Adults.

10 And so I can't really separate the processes 10:35:46
11 of writing these papers from, you know, the submission
12 of documents in this particular case.

13 But in a literal answer to your question, did
14 I -- did I review any particular documents in -- in --
15 in preparation for this testimony today, this 10:36:07
16 deposition today? The answer is no. But the process
17 of writing articles is a deep, you know, dive into all
18 kinds of issues and -- so I'm busy with this -- these
19 sub- -- these topic areas.

20 But I guess the answer to your question is no. 10:36:31

21 BY MS. HARTNETT:

22 Q Thank you. And what I need to understand
23 and -- and find a way to get that information from you,
24 notwithstanding your counsel's objection, but he should
25 make any direction he sees fit to make, in -- in your 10:36:46

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1 expert report, you refer to certain materials in this
2 case that you had reviewed as a basis for your opinion.

3 Do you recall that?

4 MR. BROOKS: Do you want to direct the
5 witness's attention to what you're referring to? 10:37:03

6 MS. HARTNETT: Yeah, I can do that, I guess.

7 BY MS. HARTNETT:

8 Q You reviewed Dr. Adkins' and Dr. Safer's
9 declarations before you -- as part of your materials
10 that you rely on in your expert report; correct? 10:37:13

11 A Yes.

12 Q And what I'm trying to understand is whether
13 or not you are going to rely on Dr. Adkins' or
14 Dr. Safer's supplemental declarations as part of your
15 expert opinion in this matter. 10:37:29

16 MR. BROOKS: Counsel, let me -- I'll object
17 and, I think, make a suggestion.

18 The -- is your question whether he has
19 considered those rebuttal reports submitted by
20 Dr. Adkins and Safer? Or did you mean something else? 10:37:47

21 MS. HARTNETT: I would like to know if he has
22 reviewed the expert -- supplemental expert report of
23 Dr. Adkins.

24 Will you allow him to answer that question?

25 MR. BROOKS: I will. 10:38:02

1 THE WITNESS: I think at one point I did.

2 BY MS. HARTNETT:

3 Q Do you understand that Dr. Adkins wrote an
4 initial report and then a rebuttal, including to your
5 report?

10:38:13

6 A Yes.

7 Q Have you reviewed Dr. Adkins' rebuttal,
8 including to your report?

9 A Not -- not in preparation for this deposition,
10 no.

10:38:23

11 Q And did you review Dr. Safer's rebuttal
12 declaration in this case, ever?

13 A I think I have. Yes, I --

14 Q And have you --

15 A I --

10:38:36

16 Q Okay.

17 A I have, yeah.

18 Q And have you reviewed the declaration of
19 Aron Janssen in this matter?

20 A Of Aron who?

10:38:43

21 Q Janssen.

22 A I can't recall that. I may have.

23 Q He's a physician at Chicago Children's
24 Hospital. Is that ringing a bell?

25 A No.

10:39:02

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1 Q Okay.

2 A It's ringing a faint bell.

3 Q All right. If you could go into your "Marked
4 Exhibits," there should now be a marked Exhibit 86.

5 MR. BROOKS: I have that on the screen. 10:39:23

6 MS. HARTNETT: Thank you, Roger.

7 And this is a document that starts with the
8 page that says "Exhibit A," and then it goes on to --
9 it's an attached expert declaration.

10 BY MS. HARTNETT: 10:39:38

11 Q Do you see this document, Dr. Levine?

12 A We're scrolling through it here.

13 Expert declaration of Dr. Levine. Robert
14 Ferguson -- Tingley, yeah, okay.

15 Q And so what -- what is this document, if you 10:39:54
16 know?

17 A This is something I submitted several years
18 ago of -- I think it was about an attempt to censor a
19 psychologist who wanted to provide a certain
20 exploration with a patient, and -- and so I was 10:40:19
21 offering an opinion about, I guess, the
22 psychotherapeutic evalua- -- the evaluation of
23 psycho- -- the psychotherapeutic processes involving
24 patients.

25 Q And just turning to page 2 of this document, 10:40:38

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1 do you see it says -- are -- are you on page 2 of the
2 PDF?

3 A Let's see. How do I know that?

4 Q The page after the page that says "Exhibit A."

5 A I -- I'm on the page that is the title page 10:40:54
6 that says, Expert Declaration of Dr. Stephen Levine.

7 Q And, Dr. Levine, the caption of this page says
8 "Expert Declaration of Dr. Stephen B. Levine in Support
9 of Plaintiff's Motion for Preliminary Injunction";
10 correct? 10:41:14

11 A Correct.

12 Q And I know we had some discussion before the
13 break about what the word "support" means. In this
14 case, did you understand that your declaration was
15 being submitted in support of the plaintiff challenging 10:41:25
16 the practice that you were referring to?

17 A I guess I now understand that, yes.

18 Q Okay. And just flashing back to the end of --
19 this is a declaration that was submitted in a matter in
20 court in Washington State. 10:41:46

21 Do you see that?

22 A Yes.

23 Q And then at the -- it's -- you can page
24 through, but it appears that you signed this
25 declaration on May 10th, 2021; is that correct? 10:41:57

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1 MR. BROOKS: Well, we'll go to the end and see
2 what we see.

3 THE WITNESS: Let's see. May 2021.

4 BY MS. HARTNETT:

5 Q Okay. And what -- what, if any, additional 10:42:17
6 involvement have you had with the Tingley matter other
7 than submitting this declaration?

8 A I think none.

9 Q Okay. Now, just turning back to the first
10 page or any page, frankly, in this document, you can 10:42:41
11 see there's a caption on the top of the page there.

12 Do you see "Case 2:21-cv-00316"? Do you see
13 that?

14 A Yes.

15 Q And that, I would represent, is the caption 10:42:51
16 for the current case, B.P.J.

17 And this was Exhi- -- this -- this
18 declaration, the version that I put before you, is
19 actually the version that was attached in opposition to
20 plaintiff's motion for preliminary injunction in this 10:43:11
21 case.

22 Did you have an understanding that your
23 declaration from the Washington case was going to be
24 submitted as an attachment in support of the defendants
25 in this matter at the preliminary injunction stage? 10:43:25

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1 MR. BROOKS: Objection.

2 THE WITNESS: No.

3 BY MS. HARTNETT:

4 Q Were you asked to -- for permission before the
5 defendants in this case attached your Washington 10:43:44
6 declaration to the opposition to the preliminary
7 injunction motion in this case?

8 A No.

9 Q Do you recall whether you were asked to submit
10 an expert declaration at the preliminary injunction 10:43:58
11 phase of this case?

12 A Would you clarify that question? I'm not
13 exactly sure what you're asking.

14 MS. HARTNETT: Could the reporter read back my
15 question. 10:44:29

16 (Record read.)

17 MR. BROOKS: Objection.

18 THE WITNESS: I don't know what the
19 preliminary injunction phase was. I don't know the --
20 who the implied person who might have asked me. I -- 10:44:38
21 I -- I'm -- I'm a psychiatrist. I am not a -- I'm not
22 very knowledgeable about your -- about the law and the
23 legal processes.

24 So I -- I just can't answer the question
25 because I don't I understand the terms. 10:44:56

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1 Perhaps you can simplify the question for me.

2 BY MS. HARTNETT:

3 Q What I'm trying to understand -- and thank you
4 for -- for that.

5 I'm trying to understand whether you are aware 10:45:09
6 that your declaration from the Tingley matter was
7 submitted in opposition to the plaintiff's motion for
8 preliminary injunction in this case.

9 MR. BROOKS: Objection; asked and answered.

10 THE WITNESS: I thought I already answered 10:45:23
11 that question.

12 By MS. HARTNETT:

13 Q Okay. Right. And you said, I think, that you
14 were not aware. And then what I'm asking you is, were
15 you asked to prepare a declaration specifically for 10:45:30
16 this case at the preliminary injunction phase?

17 MR. BROOKS: Objection; asked and answered.

18 THE WITNESS: Again, I don't know the phases
19 of this case. And the preliminary injunction phase
20 is -- I don't understand specifically what that means 10:45:49
21 in terms of the long process of adjudication in this
22 case.

23 I was asked to submit a report for this case,
24 but I was not told it was for a preliminary injunction
25 or what- -- an injunction that's not preliminary. 10:46:05

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1 I simply don't know the answer to your
2 question.

3 BY MS. HARTNETT:

4 Q Thank you. When were you retained in this
5 case, B.P.J.? 10:46:15

6 MR. BROOKS: Objection.

7 If you recall.

8 THE WITNESS: I presume it was sometime in
9 2021, but I don't recall the specific date. I -- you
10 know, I could find out, but right now, I -- I -- I 10:46:33
11 can't tell you a specific date. I would presume in the
12 last half of 2021.

13 BY MS. HARTNETT:

14 Q Do you have any objection to your declaration
15 from one case being submitted in another case without 10:46:51
16 your approval?

17 MR. BROOKS: Objection.

18 THE WITNESS: Personally do I have an
19 objection for people using my previous testimony? Yes.
20 I don't -- I don't think that's fair to me because 10:47:06
21 every case is somewhat different. And it feels like
22 it's my work product and that -- but the truth is that
23 I'm naive about the -- about the legal processes, and I
24 think when -- the first time I submitted an expert
25 opinion report, I was shocked that people had read it 10:47:30

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1 who weren't involved in the case.

2 So there was this problem with Dr. Levine not
3 being a forensic psychiatrist, just did not understand
4 about what is public and what is not public when it
5 comes to legal documentations. 10:47:51

6 I think I subsequently learned that -- that
7 lots of people read my reports who have nothing to do
8 with the matter at hand because lawyers are looking for
9 experts and precedents and so -- and arguments and so
10 forth. 10:48:12

11 So in a -- in a personal sense, I have some
12 kind of objection to that. It doesn't feel fair to me,
13 but it's also a reflection of my naivety about this --
14 my past naivety about this matter -- about legal
15 matters. 10:48:28

16 BY MS. HARTNETT:

17 Q Thank you. I have added a different --
18 another exhibit that I would like to introduce into the
19 folder, if you could refresh.

20 MR. BROOKS: 87? 10:48:44

21 MS. HARTNETT: That's correct.

22 MR. BROOKS: Shall I open that now?

23 MS. HARTNETT: Yes, if you would.

24 (Exhibit 87 was marked for identification
25 by the court reporter and is attached hereto.) 10:48:48

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1 BY MS. HARTNETT:

2 Q And, Dr. Levine, I've marked as Exhibit 87
3 your expert report and declaration in this matter dated
4 February 23rd, '22.

5 Could you please just take a moment to look 10:49:04
6 through the document.

7 MR. BROOKS: Well, Counsel, the document, I
8 think we'll all agree, is perhaps, what, 70-some pages
9 long, plus bibliography.

10 Would you -- what do you mean by asking the 10:49:17
11 witness to look through the document?

12 MS. HARTNETT: I was just giving him the
13 courtesy of making sure he agrees it's his expert
14 report.

15 THE WITNESS: Well, my -- my signature is on 10:49:28
16 the first page.

17 BY MS. HARTNETT:

18 Q Excellent. So what is this document,
19 Dr. Levine?

20 A Well, I believe it is the report that I 10:49:34
21 submitted at the end of February about -- in this
22 matter.

23 Q Okay. And did you prepare this report?

24 A Yes.

25 Q And do you notice that this one has the 10:49:50

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1 caption for this case on it, on the first page;

2 correct?

3 A It does, yeah.

4 Q How much time did you spend preparing this

5 report? 10:50:06

6 A I could -- I would say approximately 20 to

7 25 hours. I would say closer to 25 hours.

8 Q And were you -- as a basis for this report,

9 did you use a kind of prior report that you had

10 submitted in a different case? 10:50:35

11 A Yes.

12 Q What was the basis -- like, the prior report

13 that you used as a basis for this report?

14 A Well, as I've told you already, I have

15 provided reports about the nature of what is known and 10:50:51

16 what is not known in a scientific sense about this

17 whole matter and -- so that's just part of my thinking.

18 And one report is a sort of modern refinement of a

19 previous report that -- that is selected, added to or

20 deleted from based upon the relevance to the case in 10:51:22

21 point.

22 So every -- every submission that I have made,

23 in a sense, has contributed to the -- to this current

24 report with the understanding that things have been

25 added and things have been deleted every time that I -- 10:51:44

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1 I submit a report for a case.

2 I hope that's an answer to your question.

3 Q Thank you, yes. I guess what I'm trying to
4 get at is was there a particular past report that you
5 used as a template to work from as you made your 10:52:03
6 refinements and edits for this report?

7 A No. That's -- that's -- I think the answer is
8 my -- my -- my knowledge -- my -- I think the answer is
9 to all, all my reports. I guess the answer to your
10 question is no, there's not a particular one, but there 10:52:38
11 are a series of reports, and I sometimes will select
12 from various reports.

13 Well, for example, this -- the -- the simplest
14 thing is if -- in the beginning of the report, when I
15 provide my credentials, for much of that, there is a 10:52:58
16 cut and paste phenomenon and -- and it doesn't much
17 matter which report I cut and paste from, but I only
18 added to it or subtract to it depending on, I think,
19 the relevance.

20 So, for example, if you looked at my report on 10:53:20
21 the North Carolina matter, probably there's much
22 similarity in the beginning of the report.

23 Q Thank you. So this document indicates that
24 the -- at least by my reading of it -- the only
25 documents specific to this case, B.P.J., that you 10:53:39

1 reviewed in preparing your report were the Adkins
2 declaration and the Safer declaration; is that correct?

3 A I think so.

4 Q Are you familiar with the concept of a
5 reasonable degree of scientific certainty? 10:53:57

6 A I hear it as "medical certainty." Is this a
7 reasonable degree -- can you offer this with a
8 reasonable degree of medical certainty, Doctor? And
9 when I've asked what that -- what that meant, I've been
10 told 51 percent certainty. 10:54:17

11 Q Okay. What is your understanding of -- so
12 your understanding of a reasonable degree of medical
13 certainty means 51 percent certainty?

14 A No. I think that's my understanding of the
15 legal definition of medical certainty. My clinical 10:54:35
16 idea and my scientific idea would be very different.

17 I -- I often smile when I think that -- if I'm
18 correct -- that in the legal world, medical certainty
19 refers to 51 percent.

20 Q And what is, in contrast, your clinical 10:54:58
21 standard that you were referring to?

22 A Repeat that, please. What is what?

23 Q The -- I think you were contrasting it with a
24 clinical standard; is that correct?

25 A Right. Oh, clinical or scientific. 10:55:14

1 You know, in -- in science, we have -- in
2 clinician, we have the idea of what is the risk of a
3 false positive and what is the risk of a false
4 negative, and it's a complicated statistical balance
5 between the ability to get it right or to get it wrong. 10:55:31

6 And I am -- I am one who is very humbly
7 impressed by the inability to be certain about things,
8 and I distrust certainty because facts change in
9 medicine.

10 And -- and if I could just tell you a -- an 10:55:52
11 experience that I've had. As a young person, I was
12 interested in becoming a physician, and I went to a
13 premed program at the University of Pittsburgh, and
14 somebody in that program held up Harrison's textbook of
15 medicine, which requires considerable arm strength to 10:56:13
16 lift over your head because it's probably, you know,
17 900 to a thousand pages. And he said, This is what you
18 have to learn when you're in medical school, by the
19 time you graduate medical school. I want to tell you,
20 ladies and gentlemen, that 90 percent of the things in 10:56:33
21 this book are probably not true. They probably will
22 not prove to be true in time. The trouble is I and
23 other people in medicine can't tell which of the
24 10 percent -- which of the facts are correct and which
25 of the facts are not. This is the nature of medical 10:56:48

1 science as it -- and clinical science as it moves
2 forward. We have, at any given time, a set of facts, a
3 set of principles and -- and controversy occurs, people
4 disagree and studies are done, and the facts disappear
5 and new facts take their place. 10:57:12

6 That was my introduction to medical science.

7 And as I've spent most of my -- the majority
8 of my years in this field, I still believe that that
9 little example remains to be -- remains salient and
10 something that all of us need to remember. 10:57:32

11 And so I say to you, 51 percent medical
12 certainty is a joke to me. It -- it -- I always smile.

13 Q Thank you. That -- that's helpful.

14 If we could just go through your CV attached
15 to your report, we can -- I have a few questions on 10:57:52
16 that, and then I'll turn to your report.

17 You'll have to page down a bit. It starts
18 repaginating about page -- after page 81.

19 MR. BROOKS: We are at the beginning of where
20 it says "Brief Introduction," "Curriculum Vita." 10:58:20

21 MS. HARTNETT: Okay. Thank you.

22 BY MS. HARTNETT:

23 Q Dr. Levine, is this your CV?

24 A It is.

25 Q Are you aware of anything, sitting here today, 10:58:27

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1 that needs to be updated or corrected?

2 A Probably if you scroll to the end of the
3 articles, article 151 -- publication 151.

4 MR. BROOKS: We're scrolling. We're
5 scrolling. 10:58:51

6 MS. HARTNETT: I think it might be 147.

7 MR. BROOKS: There's a lot. Pardon me. 86.
8 Here we are at -- just before --

9 THE WITNESS: Oh --

10 MR. BROOKS: -- where it says "Book Chapters." 10:59:00

11 THE WITNESS: I'm sorry, 147. 147 is -- I
12 can -- you know, today -- if I were to give you my CV
13 today, I would give you the exact citation of that
14 article.

15 And if we scroll down to the end of the CV, I 10:59:34
16 will show you something else.

17 MR. BROOKS: I'm not sure there's a further
18 question --

19 THE WITNESS: Oh.

20 MR. BROOKS: -- pending. 10:59:46

21 Or is there a question pending?

22 MS. HARTNETT: Well, yeah, I can -- I can ask
23 one.

24 BY MS. HARTNETT:

25 Q So I take it that 147 has now been published. 10:59:51

1 Is that the difference?

2 A Yes.

3 Q Did you -- is there a -- a more updated
4 version of your CV that goes up to 151?

5 A I think last week, I -- I rearranged the 11:00:03
6 numbers and somehow -- I may be -- I may -- I may not
7 be accurate at 151.

8 Q Okay. And then 146 there is what you were
9 talking about earlier, the November piece about the
10 reflections on a clinician's role? 11:00:26

11 A Yes.

12 Q Thank you. And is there anything further on
13 here you'd like to draw my attention to is in need of
14 updating?

15 A I don't know if -- if this -- this thing has 11:00:40
16 a -- this CV has a -- my -- a podcast I participated
17 in. I never -- unlike many of my colleagues, I never
18 put in my CV the talks I give and the -- you know, and
19 now there's this whole thing about podcasts. I -- I
20 gave a -- I didn't -- I was invited to give a podcast 11:01:04
21 recently and -- so I think it's on my CV, but I'm not
22 sure.

23 Q That was in January of this year?

24 A Was it in January? It was -- it was within
25 several months ago, yeah. 11:01:20

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1 Q Have you given any podcasts other than the one
2 you gave in January of this year?

3 A The -- the answer to that question is I don't
4 know. I mean, sometimes people come and talk to me
5 and -- and film me on camera and I never know what 11:01:46
6 happens to -- what hap- -- what -- what -- that
7 happens. I never know what happens to it.

8 Q Are you aware of any other -- sorry.

9 A The answer to your question is I'm not aware
10 that I have been in any other podcast, but, you know, 11:02:04
11 you may dig up some other conversation that is -- that
12 I've had somewhere along the line.

13 Q Thank you. If we could just turn back to the
14 first page of your CV, I would appreciate it.

15 Let me know when you're there. 11:02:26

16 MR. BROOKS: Yeah. We're there.

17 MS. HARTNETT: Okay.

18 BY MS. HARTNETT:

19 Q So on page 1, it notes that you are -- board
20 certified in -- in June of 1976; correct? 11:02:39

21 A Yes.

22 Q In neurology and psychiatry; is that correct?

23 A That's the name of the board that
24 psychiatrists get certified in. It's a little bit of a
25 joke that I'm -- that any psychiatrist is certified as 11:02:59

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1 a neurologist.

2 Q Have you been recertified with that
3 certification?

4 A No. I don't need to be. I'm grandfathered
5 in, as they say. 11:03:13

6 Q Thank you. Do you have any other board
7 certifications?

8 A No.

9 Q So you are not board certified in child and
10 adolescent psychiatry; correct? 11:03:27

11 A No, I'm not board certified.

12 Q Do you have any specialized training in child
13 development?

14 A Yes.

15 Q Can you describe that? 11:03:36

16 A I'm a psychiatrist. All psychiatrists are
17 trained in child development. I, in particular, have
18 been interested in the whole process of adult -- of --
19 of development throughout the life cycle and have -- I
20 think I quoted in my expert opinion report that 11:03:57
21 Tom Insel, who was the head of the NIH, NIMH, said that
22 75 percent of adult psychopathology, that is, suffering
23 as a result of mental disorders, have their origins in
24 childhood.

25 So it's hard for me to conceive that any -- 11:04:16

1 any -- any psychiatrist is not knowledgeable about the
2 processes of growing from birth to death. And I, in
3 particular, am interested in that process. I often say
4 to my -- to other people that I -- development is my
5 field. In fact, when -- when people talk about 11:04:40
6 psychoanalysis and psychodynamic psychiatry, I like to
7 rephrase those terms as developmental psychology.

8 Q Thank you. I just -- my -- my question,
9 though, was whether you have any specialized training
10 in child development. 11:04:57

11 Do you have any specialized training?

12 A Well, of course, I rotated through child
13 psychology when I was a resident. For the purpose- --

14 Q Anything else?

15 A For the purposes of questioning my expertise, 11:05:12
16 I have no specialized credentialed, certificated
17 training in child psychi- -- in -- in child
18 development.

19 However, what I'm saying to you is that my
20 understanding of being a psychiatrist and listening to 11:05:27
21 people's stories about their development all day long,
22 I don't need a special certificate to testify that I am
23 trained in -- in -- in child, adolescent, young adult,
24 middle-aged and older-aged development.

25 Q And would the answer be the same if I asked 11:05:49

1 you whether you had any specialized training in -- in
2 children or adolescents with gender dysphoria?

3 A Specialized training? I was in on the ground
4 floor of these things when there was no specialized
5 training. I was part of the -- I was part of the 11:06:12
6 process that was trying to figure out what this all was
7 about, you see. And --

8 THE WITNESS: Sorry.

9 -- I very much object to that term
10 "specialized training" because I have an understanding 11:06:30
11 of what that really -- the connotation of that term is,
12 and I don't accept that -- the legitimacy of
13 specialized training.

14 I feel what you may mean is indoctrination
15 training. I'm -- I like to distinguish between 11:06:50
16 indoctrination and education.

17 BY MS. HARTNETT:

18 Q Are you an endocrinologist?

19 Are you an endocrinologist?

20 A No. 11:07:17

21 Q And you would not hold yourself out as an
22 expert in endocrinology; correct?

23 A I'm not an expert in endocrinology.

24 Q And are you an expert in sports medicine?

25 A No, I'm not an expert in sports medicine. 11:07:33

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1 Q Are you an expert in athletic performances?

2 A I've already testified to that. The answer is
3 no.

4 Q Yeah, I'm asking because I think your attorney
5 at some point indicated that might be part of your 11:07:44
6 privileged conversation. That's why I'm asking you
7 again.

8 Do you have any -- have you ever had any
9 complaints made against you related to your medical
10 practice? 11:07:56

11 A Yes.

12 Q Could you tell me about those?

13 A Yes. We had a trans adult who wanted
14 hormones, and I was supervising a psychology intern,
15 and the -- we decided the person was mentally unstable 11:08:17
16 and was not in a position to be given hormones just
17 yet, and the patient threatened to murder the
18 psychology intern who told her that -- who told the
19 patient that answer.

20 And I -- when she told me that, I went in and 11:08:36
21 I saw the patient, and I told the -- and I discharged
22 the patient. And I said that patients have obligations
23 and doctors have obligations and you have justified the
24 rule, you have crossed over the line, and I cannot
25 allow you to continue to get care here. 11:08:59

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1 The patient then left and then reported me to
2 the State Medical Board, and the State Medical Board
3 investigated and -- and found -- and found that I was
4 perfectly justified in what I did.

5 That is the only awareness that I have of -- 11:09:21
6 of complaints to the State Medical Board about my work.

7 Q Thank you. Just back to the point, we -- we
8 were discussing the notion of specialized training a
9 minute ago.

10 Do you recall that? 11:09:40

11 A I recall.

12 Q So do you -- do you accept the legitimacy of
13 the notion of specialized training in child and
14 adolescent psychiatry?

15 A For people who are interested in having a more 11:09:58
16 extensive experience and plan to spend their lives with
17 young -- young people only or primarily, I think it's a
18 fine thing to -- to -- to -- it's just one of the many
19 houses in the big -- in the mansion of medicine and one
20 of the -- one of the subspecialties in psychiatry. I 11:10:20
21 have no objection to people becoming child and
22 adolescent psychiatrists.

23 Q And just to be clear, that's not a specialty
24 of yours; correct?

25 MR. BROOKS: Objection. 11:10:40

1 THE WITNESS: It's not formally. I -- I don't
2 define myself as a board-certified child and adolescent
3 psychiatrist, but I do define myself as a psychiatrist.

4 And as -- as I've already stated, I believe
5 that psychiatrists, over the -- during the course of 11:10:51
6 their training and -- that is, their initial education
7 and their subsequent life education, practicing
8 psychiatry, comes to understand or should come to
9 understand the influence of childhood positive and
10 negative experiences on their subsequent mental life 11:11:09
11 and behavioral life.

12 BY MS. HARTNETT:

13 Q In your mind, are the concepts of having an
14 understanding of child psychology and actually working
15 with child patients distinct notions? 11:11:25

16 A Well, I think they're -- they are to be
17 separated. One's -- one's theoretical understanding of
18 the processes of development, the stages of development
19 and understanding childhood adversities that -- that we
20 hear about all the time from adolescents and from 11:11:49
21 adults, that's different than actually, you know,
22 seeing five-year-old children or six-year-old children.

23 So I make a distinction between that, sure.

24 Q And how much of your practice throughout your
25 career has involved actually seeing children or 11:12:12

1 adolescent patients?

2 A Well, I -- I spend a lot of time with
3 adolescent patients, and I spend much less time with --
4 with children per se. I spend an enormous amount of
5 time talking about children to their parents. I mean, 11:12:30
6 conversations about childhood are about the -- my -- my
7 older patients, about their childhood, and the parents
8 that I see about their children's processes, that's
9 a -- I would say a daily occurrence in my practice.

10 Q How many child patients have you had in your 11:12:56
11 career?

12 MR. BROOKS: Objection; vague.

13 THE WITNESS: I -- I would have a very hard
14 time answering that question. I've had -- you know,
15 when -- when parents talk to me about their children, 11:13:26
16 for insurance purposes, the patient is the mother or
17 father or both; right? But the subject of our
18 conversation is the child.

19 So I don't know -- you see, and one of the
20 therapeutic activities that I do, I call "parent 11:13:47
21 guidance." And so parent guidance involves the focus
22 on the child's environment and how to improve the
23 child's anxiety problems or whatever, you see.

24 So I don't know if I -- if that constitutes
25 how many children. Can I answer that question in terms 11:14:08

1 of parent guidance?

2 I have a pediatrician, for example, as an
3 adult patient now, and he and I have spent a lot of
4 time talking about his daughter and -- and some of the
5 things I've said to him have really helped his daughter 11:14:25
6 overcome a problem. But he's my patient, you see.

7 I don't -- so I can't answer your question
8 with numerical terms and --

9 BY MS. HARTNETT:

10 Q Children can be patients; correct? 11:14:39

11 A Children can be patients, certainly.

12 Q And so I'm just asking you how many actual
13 children patients you've had over your career, if you
14 could estimate that.

15 MR. BROOKS: Objection; vague as to the term 11:14:51
16 "children."

17 THE WITNESS: Can you clarify whether -- what
18 a child is versus what a teenager is?

19 BY MS. HARTNETT:

20 Q Yeah, I'll ask you for two categories. 11:15:04

21 I'll ask you for prepubertal children.

22 How many prepubertal children have you had as
23 a patient in your career, approximately?

24 A And if I saw that prepubertal child one time,
25 would that -- would that constitute a patient? 11:15:20

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1 Q Why don't you give me your estimate of how
2 many prepubertal children you've ever seen as patients,
3 and then we can ask more questions.

4 A I would say a handful. Six.

5 Q And how many of those -- of those 11:15:35
6 approximately six did you see more than one time?

7 A I can't recall one.

8 Q And then I'll ask the same question about
9 adolescents, which I'll mean minors from puberty
10 through being a minor. 11:16:00

11 How many adolescent patients have you had in
12 your career, approximately?

13 A 50.

14 Q And how many of those have you seen more than
15 once? 11:16:14

16 A Most.

17 Q And were most of those, of the adolescent
18 patients you've seen, late adolescence?

19 A No.

20 Q Turning back to your CV, you list yourself -- 11:16:27
21 you're listed as a clinical professor at Case Western
22 Reserve University School of Medicine; correct?

23 A Yes.

24 Q Do you work at Case Western Reserve University
25 School of Medicine full-time? 11:16:51

1 A No. No.

2 Q When did you stop working full-time?

3 A In 19- -- November 1992.

4 Q Are you currently teaching any classes at

5 Case Western? 11:17:09

6 A I've never taught classes per se. That's not

7 how my teaching has ever been. If you think about a

8 college course, I have never -- I don't teach college

9 courses or graduate school courses. I provide seminars

10 sometimes. I've written articles about the sex 11:17:32

11 education of doctors and -- so over the years, I've

12 taught a number of seminars to our residents in

13 psychiatry. I teach -- I give workshops.

14 I recently, for example, gave a

15 four-hour work- -- a four-hour workshop at the Harvard 11:17:59

16 student health service for their mental health

17 professionals where I presented, you know, ideas to

18 them, and we had discussions.

19 So I teach -- I teach sometimes by giving

20 grand rounds. I -- there -- there is a named 11:18:20

21 lectureship in my honor at Case Western Reserve, and

22 once a year, I invite someone to give a talk from

23 another university about some sexual topic.

24 So I have residents who come to spend --

25 for -- I can't -- for probably -- probably -- since 11:18:44

1 1992, 1993, I've always had a resident with me who
2 comes and sees my patients with me, and they usually
3 spend six months with me, sitting in and seeing my
4 patients together.

5 So my teaching is not in the classic sense 11:19:03
6 that -- that the average layperson would think of
7 teaching classes. It's -- it's much more -- you know,
8 coming in and seeing how an older doctor does work,
9 has, quote, therapy.

10 I also, since 1977, have led two clinical case 11:19:26
11 conferences a week, and residents and medical students,
12 depending on the year, medical students, residents and
13 members of the community come in to those conferences
14 and we discuss cases.

15 So I have multiple avenues, multiple ways of 11:19:45
16 being a teacher, but none of them are through
17 coursework per se.

18 Q Thank you.

19 A I forgot to tell you. I also sometimes am
20 invited to give continuing education lectures. And, 11:20:02
21 for example, at the -- I've given courses, for seven
22 years in a row, at the American Psychiatric Association
23 on sex and love, mostly love I use as -- as the title,
24 and we talk about sexual problems and the barriers to
25 loving. 11:20:25

1 And this year's APA meeting, I -- I am
2 presenting a symposium with three colleagues on whether
3 or not this is time to reexamine the best practices for
4 transgender youth.

5 So all those things are -- in my review, are 11:20:39
6 -- are my teaching.

7 Q I was going to ask you about the May
8 presentation.

9 Who are your copresenters for that?

10 A Sasha Ayad, Lisa Marciano and Ken Zucker. 11:20:55

11 Q Thank you. When is that expected to be
12 presented?

13 A May 24th.

14 Q And do you know if there are other panels or
15 presentations regarding the care of transgender 11:21:15
16 patients at that conference?

17 A There probably are, but I'm -- I haven't seen
18 the entire program. But -- but there are usually --
19 there usually are one or two presentations.

20 Q And you said it was Sasha Ayad, Ken Zucker. 11:21:29
21 And who was the third person?

22 A Lisa Marciano.

23 Q Right. So I just had one -- a couple of
24 follow-up questions about the discussion we were having
25 about seeing prepubertal and adolescent patients. 11:21:46

1 When is the last time you saw a prepubertal
2 child patient?

3 A Physically saw?

4 Q Or -- or virtually. I mean, as your patient.

5 A Maybe two years ago. 11:22:20

6 Q And how about an adolescent, meaning puberty
7 while -- through being a minor?

8 A Three weeks ago.

9 Q And what was the age of that patient?

10 A 17. 11:22:44

11 Q Okay. Let's just turn to page 2 of your CV.

12 I had a couple of questions there.

13 MR. BROOKS: Just checking --

14 MS. HARTNETT: I'm just --

15 MR. BROOKS: Since it's been an hour, I was 11:23:00

16 just checking. The witness says he's fine and doesn't

17 need a break yet.

18 MS. HARTNETT: Okay. Please let me know.

19 This is --

20 MR. BROOKS: We're on -- 11:23:08

21 MS. HARTNETT: So --

22 MR. BROOKS: -- the next page. If you'll
23 direct -- I can't fit the whole page on the screen at a
24 time, so you have to direct me to portions of it.

25 MS. HARTNETT: Okay. It's -- I'm looking 11:23:16

1 at -- under "Professional Societies."

2 MR. BROOKS: All right. I have it up.

3 BY MS. HARTNETT:

4 Q Dr. Levine, on page 2 of your CV, you list
5 professional societies; correct? 11:23:28

6 A Yes.

7 Q Is the Cochrane Collaborative a professional
8 society?

9 A Is the what?

10 Q The Cochrane Collaborative. 11:23:40

11 A I don't know the answer to that question. The
12 Cochrane Library, you're talking about?

13 Q The Cochrane Collaborative.

14 A Cochrane Collaborative.

15 Well, I -- the word "Cochrane" is -- is what 11:23:54
16 comes to mind. It -- the second word changes from
17 whomever is using it.

18 I don't think it's a society. It's an
19 organization that does objective appraisal of -- of
20 scientific questions or controversies. And I -- I 11:24:13
21 don't -- I never thought about that as a society;
22 therefore, it's not listed there.

23 Q Okay. And I apologize. I believe I misstated
24 the name of it. It's on paragraph 4 of your report,
25 which you can look back to, but it then will require 11:24:31

1 flipping forward again.

2 You discussed being an invited member of the
3 Cochrane Collaboration subcommittee, and so I was just
4 trying to understand whether the Cochrane Collaboration
5 is a professional society. 11:24:42

6 A Well, it's an organization, and it's an
7 organization devoted to the objective appraisal of
8 issues that are controversial in medicine, throughout
9 medicine, every branch of medicine, every specialty of
10 medicine. It's an older institution, and it's among 11:25:02
11 the most highly respected institutions about objective
12 scientific appraisal of clinical work, and I -- I am on
13 the -- one of their committee- -- I'm on two of their
14 committees, actually.

15 Q Which committees are you on? 11:25:20

16 A It's the evaluation of puberty blockers and
17 the evaluation of cross-sex hormones for transgender
18 teens.

19 Q Do you know how many committees the
20 Cochrane Collaboration has? 11:25:35

21 A No. I think it's many decades old, and it --
22 that's -- but the answer to your question is I don't
23 know.

24 Q Are you a member of the Cochrane
25 Collaboration? 11:25:53

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1 A I'm a member of those subcommittees.

2 Q And can you describe your work on those
3 subcommittees? What does that entail?

4 A I'm hesitating to answer that question because
5 you're going to ask a follow-up question, and it is my 11:26:12
6 understanding that until the publication of our work is
7 finished -- is published, our work is published, that
8 we are not to discuss the processes and the content
9 of -- of that.

10 So I -- I feel constrained to, you know, ask 11:26:35
11 you not to ask me more questions about that.

12 MR. BROOKS: Well, I -- I'm -- I'm not going
13 to instruct the witness either way. I will advise the
14 witness that we can, I'm sure with counsel's agreement,
15 designate a portion of the transcript as confidential 11:26:50
16 and kind of proceed question by question as you are
17 comfort- -- as you are -- as you feel able, given --
18 I -- I don't know the nature of your commitments to the
19 organization.

20 But we can designate a portion of the 11:27:04
21 transcript as confidential, which will make it
22 available to attorneys representing parties in this
23 case but would prevent it from being published
24 generally.

25 So I -- I -- I offer that. I don't -- I don't 11:27:18

1 represent Dr. Levine, and I don't know that in
2 connection with that -- that professional activity, and
3 I don't know the nature of the obligations, but I'd
4 just advise the client of that pos- -- of that --
5 Dr. Levine of that possibility. 11:27:37

6 If you want --

7 BY MS. HARTNETT:

8 Q Does your work with the Cochrane -- does your
9 work with the Cochrane Collabor- -- Collaboration
10 affect your -- sorry. 11:27:46

11 Has your work on the Cochrane Collaboration
12 informed your opinions in this matter?

13 A My work with the Cochrane group, in reading
14 about the evidence on those two -- on that subject of
15 puberty blockers adds to my -- I should say there's -- 11:28:17
16 I'm hesitating because I really don't know whether I
17 should be saying anything about this, even answering
18 your reasonable question.

19 Q I appreciate that, but --

20 A Pardon me? 11:28:51

21 Q -- we do need to know this for your views, and
22 so I would ask if we -- could you -- could -- are you
23 able to answer my questions and we can designate this
24 portion of the transcript as confidential, meaning it
25 would not be publicly disclosed? 11:29:03

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1 A There's nothing that I have -- there's nothing
2 that I have seen in my work with Cochrane that has led
3 me to modify what is in that report.

4	Q	Can you please generally describe what the	
5		nature of your work is with Cochrane?	11:29:20

6 A It is to read and respond to summaries of the
7 data, various studies. It has been to help
8 conceptualize what the issue is and what measurements
9 we need -- are needed in order to answer the question
10 in the future about a more -- to provide data in the 11:29:43
11 future if -- based on studies. It's been about trying
12 to limit the number of issues that need to be measured
13 to -- in outcome studies in order to be practical
14 versus comprehensive.

15 So my work has been to participate with other 11:30:06
16 people in Zoom discussions after we read documents and
17 to given our opinions about draft documents.

18 And you may or may not know how Cochrane
19 works, but it's a series of -- like, our subcommittee
20 goes through a number of other committees above them to 11:30:31
21 be consistent and -- with the traditions of Cochrane.

22 And so I'm not, you know, privy to the
23 committees above the subcommittee. I just sometimes
24 hear about, learn about, their -- their responses to
25 druff -- draft reports. 11:30:54

1 So I think that's my answer to your question.

2 Q Okay. Are you a member of the Society for the
3 Scientific Study of Sexuality?

4	A	The -- oh, no longer.
---	---	-----------------------

5 Q What is the Society for Scientific Study of 11:31:19
6 Sexuality?

7 A It's a bunch of clinicians who are
8 interested in -- it's a bunch of clinicians who are
9 interested in providing services for people's sexual
10 problems. 11:31:36

11 Q And you ended your membership there in 1999?

12 A Yes, apparently so.

13	Q	Why?
----	---	------

14 A Apparently so. I -- I -- if I hadn't looked
15 at my CV, I wouldn't have been able to answer your 11:31:56
16 question.

17 Q Okay. I'm sorry, I was asking why you stopped
18 being a member in 1999.

19 A Oh. Because I felt that the majority of the
20 membership thought very differently than me. They 11:32:15
21 weren't -- they were mostly Master's prepared people.
22 They included people who were sexual surrogates. It
23 was a potpourri of people interested in human sexuality
24 that did not have my academic interest in sexuality.

25	I was interested, I guess -- back then, in the	11:32:39
----	------------------------------------------------	----------

1 '90s, there was the -- there was the Society for Sex
2 Therapy and Research, and there was this society.
3 Quadruple S, it's called. And this was -- and there
4 was another society called AASEC- -- AASECT. And
5 the -- the range of professional degrees, the people 11:32:59
6 who had -- the people in those societies had different
7 ranges of professional degrees, and they had different
8 interest in -- sort of an understanding of sexual
9 disorders and in research, and I thought that the
10 society for scientific study of sex really -- I thought 11:33:23
11 that the activities of the organization did not rise to
12 the level of -- of the title of their organization,
13 that it really wasn't scientific.

14 And, you know, it is amazing to me what --
15 what people call -- who wrap themselves in the mantle 11:33:49
16 of science that really don't have a concept of science.

17 So I -- you know, when I was younger, I wanted
18 to be part of the scene and -- and when I got into part
19 of the scene, I didn't want to be part of the scene.

20 Q Are you aware of the Society for Evidence 11:34:06
21 Based Gender Medicine?

22 A Yes.

23 Q And does that go by an acronym?

24 A Is what?

25 Q Does that go by an acronym? 11:34:15

1 A Yes. SEGM.

2 Q SEGM. Are you a member of SEGM?

3 A I contributed -- when I -- when I learned
4 about SEGM probably a year and a half ago, two years
5 ago, I -- I felt that I -- I wanted to support that 11:34:35
6 because they were interested in evidence, in scientific
7 evidence, so I sent them a check for \$200.

8 So I don't know if I'm a supporter of it or --
9 but I -- they consider me to be an integral and
10 important member of their society. So I guess, based 11:35:02
11 on the fact that I gave them a one-time check of \$200
12 and they hired me to write a -- to -- to develop a
13 paper and they put me on a subcommittee to talk about
14 psychotherapy of adolescents, so I guess I am a member
15 of SEGM. 11:35:21

16 I think I'm a valued member of SEGM.

17 Q Understood. Sorry, you said you were on the
18 psychotherapy -- child psychotherapy subcommittee?

19 A I think we should call it an adolescent -- it
20 doesn't exist anymore. We met -- we met every two 11:35:45
21 weeks for almost a year, but I certainly was an active
22 participant of that.

23 Q And what -- what was the work of that
24 subcommittee?

25 A It was talking about what -- it was talking 11:36:01

1 about how to develop case histories that would teach
2 mental health professionals, in general, on how to
3 approach a -- an -- an approach to transgender children
4 and adolescents.

5 As you probably know, there has been, in the 11:36:33
6 last ten years, a dramatic increase in the number of
7 teenage children who are declaring themselves to be
8 trans people. And so the number of, quote, experts --
9 the epidemiology is such that there is enormous
10 pressure on a -- on the few people who say they're 11:36:53
11 interested in gender, taking care of gender cases.

12 So SEGM was trying to develop concepts that
13 could be taught to people in the community who are not
14 experts. We are trying to interest them in providing
15 psychiatric services, psychological services to 11:37:14
16 families and to the -- the patients themselves.

17 And so we were talking about how to -- how to
18 achieve that, whether we should publish -- whether we
19 should give a conference, whether we should -- they
20 just -- they talked about various ways of -- of 11:37:32
21 informing -- of getting more mental health
22 professionals to -- to stop ignoring this problem and
23 to be interested in -- in how to help these kids and
24 their families.

25 Q Okay. Thank you. 11:37:56

1 So you said that that subcommittee is no
2 longer meeting?

3 A That particular committee is no longer
4 meeting, as far as I know. But that -- but SEGM
5 sponsors many things that I'm totally unaware of. 11:38:07

6 Q Was there a work product that came out of that
7 committee?

8 A Well, in some sense, my paper, my most recent
9 paper, didn't come out of that committee, but it came
10 out of the deliberations of that committee because one 11:38:24
11 of the strategies that SEGM had is that they wanted
12 to -- they wanted to put things in the literature
13 that -- that were based on evidence rather than based
14 on precedent.

15 And so I think that led to the publication of 11:38:45
16 my -- of 147.

17 Q What do you mean, precedent?

18 A Well, as you may or may not know, there's a
19 60-year history of -- of trying to find treatments for
20 transgendered individuals and -- so there has been a 11:39:08
21 precedent of treatment over the years that has preceded
22 the -- the -- the scientific demonstration of the
23 efficacy and the long-term outcomes of that treatment.

24 So I would say that precedent is a -- is a
25 very important influence in how transgender people are 11:39:30

1 being treated today and -- so that's how I use the term
2 "precedent." That is, we have patterns or fashions of
3 treatment that have gone in -- far in advance of the
4 scientific demonstration of the efficacy and were
5 the -- and the long-term outcomes of those treatments. 11:39:55

6 So that's the term precedent, as I -- as -- as
7 how I use it or how I think about it.

8 Q And was your -- I think your testimony was
9 that you were in the kind of ground floor of starting
10 that precedent; is that correct? 11:40:10

11 A I -- well, if -- well, the ground floor really
12 began in the '70s, and I was --

13 Q I'm sorry, did your counsel say something?

14 MR. BROOKS: No. I looked at him. He looked
15 at me. I didn't say anything. 11:40:28

16 THE WITNESS: Yeah.

17 MS. HARTNETT: Just for the record, the
18 counsel and the witness appeared to be exchanging some
19 sort of a glance, but please continue.

20 THE WITNESS: So the ground floor has to do 11:40:37
21 with the Harry Benjamin International Dysphoria
22 Association, which I think I joined in 1974 or
23 something like that, and I was in that program or in
24 that -- that associ- -- whatever you call that, a
25 society or something. I was in that professional 11:41:02

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1 organization for many, many years. And in 19- -- when
2 the fifth standard of care was being thought about, I
3 was named to be the chairman of the writing group that
4 made what was called the Fifth Edition.

5 So -- 11:41:25

6 BY MS. HARTNETT:

7 Q So you were part of creating the precedent;
8 correct?

9 A Yes. The only objection I had, what is ground
10 floor. That's the only word I was responding to. I 11:41:34
11 didn't know what ground floor meant.

12 Q Fair enough. So back to SEGM. Were you part
13 of helping to develop treatment guidelines for the
14 treatment of gender dysphoria with SEGM?

15 A I don't know that SEGM has ever issued 11:41:52
16 treatment guidelines. In a sense, my latest
17 publication is -- is probably in that ballpark.

18 What we're trying to do is to -- I think what
19 we are trying to do is -- is create treatment
20 guidelines. 11:42:19

21 You know, Sweden, Finland, the UK and France
22 have all come out and said that -- let's slow this
23 down, let's be very careful. Even -- even in the
24 United States, there are people who used to be on
25 this -- sort of on a different -- they had a -- they 11:42:46

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1 had a different treatment guidelines.

2 There's been a wave of objectivity --

3 Q I'm sorry to interrupt. I'm sorry to
4 interrupt you, but I -- I really need to ask you to
5 answer my question. And I -- I think we're -- my -- my 11:42:57
6 question was just whether SEGM is developing treatment
7 guidelines.

8 A I think it's the aspiration of SEGM to develop
9 development treatment guidelines in keeping with what
10 is happening scientifically and -- in terms of 11:43:13
11 objective reviews.

12 So I'm not so sure that SEGM has published
13 treatment guidelines yet, but I do think they're
14 interested in -- in providing a different set of
15 guidelines that may have dominating the United States 11:43:34
16 and European countries in the past. And Australian and
17 compani- -- countries in the past --

18 Q Are you part -- are you part of any effort at
19 SEGM to develop treatment guidelines on a going-forward
20 basis? 11:43:55

21 A No, not directly, but I do --

22 Q Are you involved --

23 A I do believe that my recent article will be
24 read by people and considered by people who are
25 going -- if -- if they do develop treatment guidelines. 11:44:12

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1 Q Is -- is -- am I understanding correctly that
2 your article was an effort, in conjunction with SEGM,
3 to affect the practitioner community about how you view
4 treatment should be provided?

5 A To the extent that treatment should be 11:44:35
6 provided based upon a thorough informed consent
7 process, that my article describing informed consent
8 would be affirmative answer to your question that I --
9 I'm hoping that the influence of my article will
10 influence all treatment guidelines in the future, 11:45:01
11 regardless of who issues those guidelines.

12 MR. BROOKS: Counsel, when --

13 BY MS. HARTNETT:

14 Q Are you --

15 MR. BROOKS: When you come to a convenient 11:45:10
16 point, let's take one more break and have one more
17 stint before lunch. I don't mean to disrupt the line
18 of questioning, but when you come to a point, it would
19 be good.

20 MS. HARTNETT: I appreciate that. I have a 11:45:20
21 couple more questions on this, and then we can take a
22 break.

23 BY MS. HARTNETT:

24 Q Are you actively involved in any SEGM work
25 currently? 11:45:29

1 A No.

2 Q Do you know where SEGM receives its funding
3 from?

4 A I believe that -- that the hundred or so
5 people that are, quote, members contribute something, 11:45:55
6 but it's something as modest, perhaps, as I gave, \$200.
7 There must be a large donor or set of donors.

8 And the answer to your question is I don't
9 know the answer.

10 Q Is there someone at SEGM that you think would 11:46:15
11 know that answer?

12 A Yes.

13 Q Who is that?

14 MR. BROOKS: Objection.

15 THE WITNESS: There are several people. 11:46:26

16 May I answer that question?

17 MR. BROOKS: You may answer.

18 THE WITNESS: Stephen Beck, Dr. Stephen Beck,
19 and Ema Zane, E-M-A Z-A-N-E.

20 MR. BROOKS: And, Counsel, we will designate 11:46:47
21 the testimony about finances of SEGM as confidential.

22 MS. HARTNETT: We can -- oh, we can
23 provisionally do that. That's fine.

24 BY MS. HARTNETT:

25 Q You mentioned -- I have just one more. 11:46:59

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1 You -- you mentioned you were a valued member
2 of SEGM. Is that just your -- is there a special group
3 of people that are valued, or do you just kind of view
4 yourself as having a valued role in the organization?

5 A Well, I was asked to develop this paper or a 11:47:12
6 series of papers on informed consent, and to me, I
7 considered that a compliment, and it was based upon my
8 previous publications about this matter.

9 And in the concept -- and in the discussions
10 of the committee on psychotherapy, I just got the sense 11:47:41
11 that -- I offered an opinion and people really -- they
12 often said that was helpful or clarifying or, you know,
13 really good or "Can I use that term?" or whatever.

14 So whatever the subjective appraisal I was
15 making of my role, my status, among these very 11:48:04
16 respected people, I believed that I was a valued
17 member. You know, I could be --

18 Q Do you think you're the most --

19 A -- delusional about that.

20 Q Do you think you're the most -- are you the 11:48:18
21 most highly credentialed professional in SEGM?

22 A No.

23 Q Huh?

24 A No.

25 MS. HARTNETT: Okay. I think this is a good 11:48:34

1 time for a break.

2 MR. BROOKS: All right.

3 THE VIDEOGRAPHER: Off the record at

4 11:49 a.m.

5 (Recess.)

12:00:19

6 THE VIDEOGRAPHER: We are on the record at

7 12:01 p.m.

8 MS. HARTNETT: Thank you.

9 BY MS. HARTNETT:

10 Q Welcome back, Dr. Levine.

12:00:40

11 A Thank you.

12 Q I think I want to turn from your -- we were

13 talking through your CV a bit and now just go to your

14 report. So if you could -- I'm going to be asking a

15 question about paragraph 5, if you want to pull up that 12:00:53

16 page?

17 MR. BROOKS: We now have paragraph 5 on the

18 screen.

19 MS. HARTNETT: Great.

20 BY MS. HARTNETT:

12:01:14

21 Q So you, in the first sentence of paragraph 5,

22 say you first encountered a patient suffering with

23 what -- sorry -- "what we would now call gender

24 dysphoria in July 1973."

25 Do you see that?

12:01:30

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1 A Yes, I do.

2 Q Who was that patient?

3 MR. BROOKS: I will, of course, object to the

4 extent you're asking the doctor to disclose

5 confidential --

12:01:43

6 THE WITNESS: Actually --

7 MR. BROOKS: -- identifying information.

8 THE WITNESS: Actually, the patient and I

9 wrote a paper together and -- and so the patient has

10 used the name, so I feel like I can tell you the name. 12:01:52

11 BY MS. HARTNETT:

12 Q That's why I was asking.

13 A Yeah. So the name was Rutherford Shumaker.

14 Q And did you refer to the patient as

15 "Rutherford" or some other name?

12:02:07

16 A Well, the name of the -- the name of the

17 article was Increasingly Ruth: Towards an understanding

18 of sex reassignment surgery.

19 And so Rutherford, in, I think -- became Ruth.

20 So Ruth and I published that paper, and then I wrote a 12:02:32

21 follow-up to that paper after Ruth committed suicide in

22 her family's home. But that was 1983. I'd have to

23 check the CV.

24 So that was my -- the man coming to me as

25 Rutherford, who eventually became Ruth, came to me in 12:02:56

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1 July of 1973.

2 Q And do you recall how long after you first
3 encountered that patient you encountered your next
4 patient that was suffering from what we would now call
5 gender dysphoria? 12:03:11

6 A Oh, it probably -- it was probably a couple of
7 months.

8 The answer to your question, I don't
9 specifically recall, but --

10 Q Okay. 12:03:26

11 A -- I -- I -- there was enough pressure by
12 patient request for care that we started this -- this
13 clinic.

14 Q Understood. And you note here, on your
15 paragraph 5, you also founded the Case Western Reserve 12:03:37
16 University Gender Identity Clinic; correct?

17 A Correct.

18 Q And you note, later in that paragraph, that in
19 1993, the Gender Identity Clinic was renamed.

20 A In 1993, I left full-time employment at 12:03:52
21 Case Western Reserve, and I continued the program, but
22 we changed the name of the program, but our work
23 evaluating and providing services for trans individuals
24 continued.

25 Q And what did you change the name of the 12:04:15

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1 program to?

2 A Well, I think we just called it the Gender
3 Identity Clinic of Levine, Risen -- Althof, Levine and
4 Risen, which was the name of our clinical practice,
5 Althof, Levine and Risen. So it --

12:04:34

6 Q Okay.

7 A Gender Identity Clinic at ALR.

8 Q And when you -- when the university kind of
9 discontinued -- or you discontinued the affiliation
10 with the university in 1993, did you consider that to 12:04:50
11 be a dark day in the department, in the politics of the
12 department?

13 MR. BROOKS: Objection; compound question.

14 THE WITNESS: Number one, I did not
15 discontinue my affiliation. I changed my affiliation. 12:05:06
16 That is, I was salaried until 1993, and then I left the
17 university and personally, for a while, I did consider
18 it a -- a great disappointment that I left the
19 university.

20 BY MS. HARTNETT: 12:05:30

21 Q Did you consider it a dark day in the
22 department, in the politics of the department, at the
23 university?

24 A That per se wasn't the source of the darkness.

25 That day wasn't it. In my view, it's a very 12:05:43

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1 prejudicial view, the dark day came when a new chairman
2 was selected, who came aboard, who then basically ran
3 the department into a great debt, and then I and
4 several other program- -- my program and several other
5 programs needed to be cut from the department in order 12:06:07
6 to get the department back into solvency.

7 So the fact that one day I left was the
8 by-product of things that had happened over a
9 three-year period.

10 So the dark days began, I think, on day one 12:06:25
11 when the chairman came.

12 Q Thank you. Are you familiar with the
13 University Hospitals?

14 A The department of psychiatry was part of the
15 University Hospitals of Cleveland. 12:06:41

16 Q And you did your psychiatric residency at the
17 University Hospitals of Cleveland?

18 A Yes.

19 Q Do you have an affiliation there now?

20 A I do. I'm a clinical professor. 12:06:52

21 Q And how often do you -- if at all -- do you go
22 to the University Hospitals?

23 A Not very frequently. The -- the resident
24 comes to me, and I -- but I am probably going to be
25 teaching a seminar at University Hospitals in the next 12:07:13

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1 three months because I'm part of a committee to plan
2 the curriculum on sexuality and gender.

3 Speaking of education, the university --
4 other -- other institutions also asked me to teach
5 about this subject. And on August -- on April 7th, I'm 12:07:39
6 going to Akron to teach -- or virtually I'm going to
7 teach a three -- a two-and-a-half-hour seminar.

8 And I forgot to mention to you before, and I'd
9 like you to hear this, that when you were questioning
10 me about my credentials or not having a certificate 12:07:57
11 about -- in child psychiatry, you should know, I forgot
12 to tell you that Cleveland Clinic, department of child
13 psychiatry, and the University Hospitals, the
14 department of child psychiatry, sends residents to be
15 with me as part of their training in child development 12:08:18
16 and child clinical issues, child and adolescent
17 clinical issues.

18 So I think -- I just forgot to mention that.

19 Q Are you familiar with the University
20 Hospitals' LGBTQ and gender care program? 12:08:48

21 A I'm aware that it exists, yes.

22 Q Have you ever talked to any clinicians in that
23 practice?

24 A No one has ever talked to me in that practice.
25 The only time I have interaction with them is when -- 12:09:00

1 if I present grand rounds, some of those people ask me
2 a question. But they've never consulted me whatsoever
3 in the formation of their clinic and in the ongoing
4 work of their clinic.

5 Although, Cleveland Clinic has a very similar 12:09:20
6 program, and they have called me up and -- for some
7 advice sometimes.

8 But my -- my, quote, own University Hospitals'
9 place I don't really think has any people from child
10 psychiatry in it, but I'm not sure because they have 12:09:38
11 kept me away.

12 Q What do you mean they have kept you away?

13 A Just what I explained. They have never
14 communicated with me. It is -- you know, other people
15 know me as being published in this area. You know, I 12:09:54
16 think I've written 20 articles on this -- you know, I
17 have 20 or so publications in this area. You would
18 think that they would invite me or consult with me or
19 ask me questions, but I think they recognized that they
20 are part of what is called affirmative care and what I 12:10:18
21 would say, rapidly affirmative care, and -- and they
22 sense that I'm not so interested in rapid, that -- that
23 I believe that -- that I have long believed that people
24 who have this kind of dilemma need some patient time in
25 talking about this matter. 12:10:45

1 And while I can't tell you how they feel about
2 me, I can only deduce that they're not interested in my
3 concepts because --

4 Q Have you --

5 A -- they must be different than their concepts. 12:10:57

6 Q Have you offered your -- your services to
7 them?

8 A No.

9 Q You said your understanding is that they
10 provide rapid affirmative care; is that correct? 12:11:10

11 A I presume so. I -- you know, I can't
12 understand why -- why the organizers and the leaders of
13 those -- that team are not interested in anything I
14 have to say because they've never asked me.

15 Q So just because someone hasn't asked you for 12:11:29
16 your view, do you assume that they're not interested in
17 what you have to say?

18 A This -- I wouldn't say as a general principle,
19 but I would say in this case, I have long assumed that,
20 correctly or incorrectly. 12:11:44

21 Q It sounds like you don't agree with rapid
22 affirmative care; is that fair?

23 A Yes. I don't believe that people, after
24 meeting someone for an hour, for example, ought to be
25 given a firm diagnosis and a prescription for hormones. 12:12:00

1 Q Is that your definition of rapid affirmative
2 care?

3 A That would be one definition, yes.

4 Q Can you give me a more general definition of
5 what rapid affirmative care is? 12:12:17

6 A It would be -- it would be a commitment to be
7 affirmative in -- in being a cheerleader for social
8 transition or taking hormones or having one's breasts
9 removed after what I would consider to be an inadequate
10 evaluation. 12:12:34

11 So it begins with an adequate evaluation.
12 It -- it requires having an understanding of the
13 elements of informed consent. And in dealing with
14 minors, it has to do with working with not only with
15 the patient but with the parents. 12:12:51

16 So rapid affirmative care would be care that
17 does not meet my criteria for thorough evaluation,
18 including a developmental history, a process of
19 informed consent and involvement, over time, with the
20 parents so they consider the weighty -- the weighty 12:13:10
21 implications of -- of what affirmative care represents.

22 So anything short of deliberation in this and
23 careful consideration I would kind of dismiss as rapid.

24 Q If affirmative care is given with deliberation
25 and informed consideration, do you disagree with that? 12:13:33

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1 A No. No. I think parents -- parents have a
2 weighty decision to make, but they ought to be informed
3 about the state of science. The -- the health tour
4 benefits have to be understood in terms of the
5 scientific likelihood of achieving those benefits. And 12:13:51
6 they have to understand the short-term medical but more
7 important the long-term psychosocial risk of what
8 they're doing.

9 And if those competent parents, knowing the
10 child as they know them, decide, after they're 12:14:09
11 informed, they -- they have my blessing to socialize
12 their child in the opposite gender.

13 Whether I think in that particular case it's a
14 wise thing or not, it's not my decision to make. I
15 don't actually believe that people like me ought to be 12:14:29
16 recommending. I think we ought to be educating,
17 evaluating and informing and the parents and the child
18 make the decision with my supportive help, both on the
19 positive side and the negative side.

20 I am to be the trustee, informer of what 12:14:45
21 science knows, and I believe that clinicians who don't
22 know science, who actually think they can evaluate this
23 in a -- in -- in a -- in an hour, I just think that's
24 not good care.

25 Q Is your view that the clinicians at the 12:15:06

1 University Hospitals LGBTQ and gender program don't
2 know science?

3 A I don't know what they know. I don't know
4 what they know. I have no views about that because I
5 have no means of knowing, only that I get to see people 12:15:22
6 brought to me after they've gone to various affirmative
7 care programs and the parents are horrified at the
8 recommendations that are being made. So --

9 Q How many -- sorry. Go ahead.

10 A But in answer to your specific question, since 12:15:44
11 I don't even know the people there and I don't know
12 what they're doing, I'm not -- I would just -- I would
13 just -- I pose these standards, and I don't know
14 whether they meet them or not.

15 I have not been impressed in general that 12:16:04
16 affirmative care programs in various cities that I get
17 to hear about meet those criteria.

18 I'm just trying to help people, you know,
19 realize the importance of trans care and -- and trans
20 care, to me, includes careful evaluation and -- and 12:16:19
21 addressing the comorbidities that are frequently
22 present in these kids.

23 And by "kids," I mean even teenagers.

24 Q Have you had -- sorry, so you -- but your
25 understanding is that the University Hospitals LGBTQ 12:16:39

1 and gender care program does provide the rapid type of
2 affirmative care; is that right?

3 MR. BROOKS: Objection.

4 THE WITNESS: I already --

5 MR. BROOKS: Asked and answered. 12:16:48

6 THE WITNESS: -- answered that question. I'm
7 not -- I'm not aware of what they do. I -- I am --

8 BY MS. HARTNETT:

9 Q Okay. Sorry, I thought you had said you
10 thought that they provided rapid affirmative care, 12:17:01
11 which is why I was asking.

12 A I wouldn't be surprised if their definition of
13 inadequate evaluation is different than my evalua- --
14 my -- my definition of an adequate evaluation.

15 Q Do you know what their definition is of an 12:17:20
16 adequate evaluation?

17 A No. And because I don't know, I don't want to
18 endorse them, nor do I want to condemn them.

19 Q What is the basis for your understanding that
20 there is kind of rapid transition care being provided 12:17:32
21 out there?

22 MR. BROOKS: Objection; vague.

23 BY MS. HARTNETT:

24 Q Sorry, let me just use your term.

25 You said rapid affirmation. 12:17:42

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1 A Well --

2 MR. BROOKS: I was objecting to the outlier as
3 vague. I'm not sure what you -- are you referring to
4 the clinic you've been discussing or something else?

5 BY MS. HARTNETT: 12:17:52

6 Q What is your basis for your view that there
7 are clinicians in the United States performing rapid
8 affirmation care?

9 A Thank you for asking that question.

10 I have been in contact with -- that is, 12:18:03

11 parents -- there -- there are parent groups who cannot
12 find -- there -- there are groups of parents who
13 brought -- were brought together, who came together,
14 bounded -- bound together in organizations who are
15 objecting to what they call rapid affirmation and the 12:18:27
16 inability to find a therapist in their community who is
17 willing to just do psychiatric care like they would do
18 psychiatric care if a child presented simply with
19 anxiety or depression or substance abuse or some other
20 behavioral problem. 12:18:48

21 The -- the basis for -- for my -- the answer
22 to your question is parents, both Cleveland parents,
23 national -- parents from all over the country and
24 parents from the UK. I am aware that parents are
25 particularly perturbed by rapid affirmation and its 12:19:07

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1 treatment, and they -- they have complaints that their
2 child is not understood; that is, their problems have
3 not been understood.

4 Q How many parents have you talked -- how many
5 parents have you talked to about their concern with 12:19:26
6 what you call the rapid affirmation model?

7 A Well, I gave a talk to 35 parents probably a
8 year ago. In 2017, I think I wrote about it in the
9 article that -- the last four or five cases that I was
10 involved with, the parents all said the same thing; 12:19:53
11 that is, they were horrified that after one hour,
12 their -- their child was diagnosed and -- and had
13 recommend- -- and had recommendations that horrified
14 them.

15 Q Sorry, how -- where was the talk that you gave 12:20:10
16 to the 35 parents? What -- what was that?

17 A It was in -- it was in my easy chair in my
18 bedroom.

19 Q What was the convening? What was the venue
20 for that? 12:20:23

21 A It was a group of parents who invited me to
22 give a talk, and what I gave a talk on was -- the
23 aspects of what -- what I knew about human identity,
24 not just --

25 Q What was -- 12:20:38

1 A -- not just gender identity.

2 Q Was this group of parents affiliated with an
3 organization, or how did they -- how did they present
4 themselves? As some sort of an organization?

5 A A woman contacted me and said that she belongs 12:20:50
6 to an organization of -- of concerned parents of trans
7 teenagers or children. I'm not sure which. Mostly
8 teenagers. She actually sent me an analysis of --
9 of -- of -- that she made, a little research that she
10 had done that demonstrated a very high intelligence 12:21:10
11 in -- of their -- all the children in this group and
12 very high incidents of autism and other developmental
13 problems and -- so she sent me that data, and she
14 wanted some advice to -- from me about how to get that
15 published. 12:21:37

16 And -- and then she invited me to give a talk.
17 When we talked, she then said she would get back to me,
18 and she got back to me and invited me to give a talk to
19 the parent group. And so that's what happened.

20 Q Is the parent group called Genspect? 12:21:51

21 A No. I think -- it -- it might -- it -- this
22 was an American group of people and --

23 Q What was the parent's name that did the
24 research?

25 A You know, I -- I would have to look that up. 12:22:15

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1 I don't remember.

2 Q I'm just going to try to -- so I appreciate
3 what you've explained.

4 Could you tell me how many actual parents have
5 described to you, personally, an experience where their 12:22:29
6 child was diagnosed and prescribed treatment in an
7 hour?

8 A Well, if -- some people, it would be two
9 hours, okay?

10 Q Let me just start with one hour. 12:22:46

11 How many parents have told you directly that
12 their child had been prescribed -- diagnosed and
13 prescribed treatment in an hour?

14 A I would say perhaps 50 percent of the people
15 who -- who have consulted me. 12:22:59

16 Q And how many people have consulted you?

17 A I really can't answer. You know, if I told
18 you 11, if I told you 16, if I told you four, I
19 would -- I would have no conviction that I -- that --
20 that that answer is correct. 12:23:19

21 I'm telling you I had the impression that over
22 and over again parents complain about this. They
23 complain about affirmation. They're afraid of
24 affirmation, what that will mean to their child's
25 future. And they complain that they can't get their 12:23:35

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1 point of view to influence their thera- -- the -- the
2 person -- their gender expert that they took their kid
3 to and -- and that they can't find anyone else who
4 has -- who has the courage, they say, to just talk to
5 their kid without saying they believe in affirmation 12:23:55
6 because that's the right thing to do.

7 Q Thank you. I -- I just -- you've talked about
8 the importance of scientific data; correct?

9 A Correct.

10 Q And you've made the representation that there 12:24:09
11 is a practice of rapid affirmation happening in the
12 United States; correct?

13 A As -- as far as I know, yes.

14 Q And what I'm trying to understand is the basis
15 for your understanding that there is a phenomenon of 12:24:22
16 rapid affirmation happening in the United States.

17 And so --

18 A Well --

19 Q -- I guess my question is -- sorry.

20 A -- the basis. And I've tried to answer the 12:24:33
21 basis is -- is that the parents who consult me all
22 tell -- pretty much all tell me the same story. It is
23 multiple patient reports.

24 And when I -- when I was on that committee
25 that we talked about before, of psychotherapy, people 12:24:52

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1 in Australia, people in Ireland, people in London, in
2 various parts of the UK and -- let me think where this
3 is a source of -- and the United States have all
4 reported to me the same thing. Everyone says the same
5 thing, that the parents complained to them about going 12:25:18
6 to specialty care which rapidly confirms the diagnosis
7 and recommends affirmation and tends to make the
8 parents feel like they're -- they're doing a terrible
9 thing by resisting transition.

10 Q You mentioned -- 12:25:39

11 A So the answer to your question is multiple
12 sources, both directly in my clinical practice, both --
13 what I read about sometimes in these legal proceedings,
14 legal documents and in -- and -- and from my
15 colleagues. 12:26:01

16 I -- I just want you to know that if -- that
17 professionals all claim to do thorough evaluations, but
18 I -- I'm not sure that our definition of thorough
19 evaluation is -- is correct.

20 Q Have you talked to any gender-affirming 12:26:18
21 professional to learn what their practice actually is?

22 A Well, I've read Dr. Adkins, for example,
23 reassurance about the thorough evaluations done in her
24 clinic.

25 And -- have I talked to any affirmation -- 12:26:40

1 well, I did talk to the Cleveland Clinic people and --
2 who are -- were sharing with me their angst about what
3 they should do with these borderline personality kids,
4 kids who aren't doing well, who don't want to focus on
5 anything but their transgender state. So they consult 12:26:57
6 me about these -- these case- -- you know, they
7 consulted me about this.

8 So I guess the answer is yes.

9 And if you ask me the number, I would say it's
10 not a large number. I don't -- and I don't -- 12:27:14

11 Q Sorry, other than Dr. -- other than Dr. Adkins
12 and whoever you talked to at the Cleveland Clinic, have
13 you -- are you -- sorry.

14 You've never talked to Dr. Adkins; correct?

15 A I've never personally spoken to her, no. 12:27:25

16 Q So other than the people at the Cleveland
17 Clinic that you referred to, have you spoken to any
18 other gender-affirming professionals about their
19 practices?

20 A Well, in these various legal matters, 12:27:37
21 oftentimes I'm asked to review case material, and I --
22 and I -- I haven't visibly, virtually, talked to -- the
23 answer to your question is no, but I -- I certainly
24 have seen materials that indicate the -- the quality of
25 the interactions that have been between the affirming 12:28:09

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1 and the professional and the patient and sometimes the
2 parents.

3 Q And you mentioned -- you mentioned multiple
4 patient reports, I think, when you were saying what the
5 basis was for your review. 12:28:24

6 Do you recall that?

7 A Yes.

8 Q Are you -- and there, you're talking about the
9 patient would be the -- the parent of the child that's
10 being cared for; right? 12:28:30

11 A Yes. I think if --

12 Q In other words, you were -- you were not
13 getting complaints from the -- the child or adolescent
14 that was being discussed; you were getting the
15 complaint from the patient parent; is that right? 12:28:45

16 A Oh, I've heard -- I -- I've heard patients say
17 that they were a little surprised by the rapidity of
18 things, yes.

19 Q Sorry, one of your child or adolescent --

20 A So it's -- 12:28:58

21 Q -- patients --

22 A It's not entirely parents, but it's largely
23 parents.

24 Q And then I've asked you how many parents
25 you've directly heard reports of -- let's just say 12:29:10

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1 two-hour or less diagnosis and treatment. How many
2 parents have you heard that from directly?

3 MR. BROOKS: Objection; asked and answered.

4 THE WITNESS: I would say 15 sets of parents.

5 And if you allow me to accept the reports of the people 12:29:31
6 on the committee, probably it's over a hundred. But,
7 you know, as I already answered, I can't really -- I'm
8 just giving you numbers because you're asking for
9 numbers.

10 BY MS. HARTNETT: 12:29:54

11 Q Well, isn't it important to have good data?

12 A You're right, it is important to have good
13 information. And data varies in its nature. And
14 parental reports that are consistent over time, to me,
15 is good data. That represents good data. That are 12:30:10
16 good data, rather.

17 Q Have you ever had a parent report to you a
18 positive experience from an affirming practitioner, as
19 you describe them?

20 A Ever had a positive experience. 12:30:35

21 Well, last Sunday morning, I gave a talk at a
22 church, and a grandmother told me that her very
23 disturbed granddaughter has transitioned to a -- living
24 as a boy and she's far less disturbed and much happier
25 and she's beginning to restart her life as a student 12:30:50

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1 now, when she couldn't function as a student before.

2 So if a grandparent -- I mean, it's -- it's --
3 today's Wednesday. So that was Sunday morning.

4 So I think -- that is not the first time I've
5 ever heard from somebody. I've also heard from 12:31:05
6 grandmothers who were deeply concerned about their
7 grandchild.

8 And, actually, come to think of it, I had an
9 interview -- yes, I -- I have heard about a -- another
10 trans male teenager who is doing very well now as -- 12:31:23
11 and much better than they were doing living as a -- as
12 a distressed female.

13 So I do have positive reports of people doing
14 well.

15 And in -- in my years of taking care of -- of 12:31:39
16 adults, I've seen some people, at least who have come
17 back in follow-up after transition, who seem to be
18 doing very well in life.

19 I'm not saying that -- so I -- you know, I get
20 both sides of the coin here. 12:32:01

21 Q You haven't undertaken a scientific sampling,
22 though, to figure out what parents' experiences are
23 with affirming practitioners; correct?

24 A I -- no, I have no follow-up study on this. I
25 am like other people who don't have follow-up studies. 12:32:18

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1 Q And it could be that parents that are having
2 negative experiences are the ones that are seeking you
3 out; correct?

4 A Yes. There's always a selection by a -- in --
5 in clinics. When -- when you have data coming from any 12:32:35
6 clinic, one of the methodologic questions is, What is
7 the selection bias?

8 And so I -- I represent a person who has some
9 kind of unknown or known reputation in the community,
10 and so people come to see me because they think I have 12:32:54
11 knowledge or attitude that is consistent with their
12 position.

13 But, you see, in the -- in the fundamentals
14 of -- of the use of statistics and creating scientific
15 methodology, selection bias is a well-known problem, 12:33:12
16 and that's one of the reasons why some studies need
17 to -- that's one of the advantages of having multisite
18 studies and multicultural -- studies from multiple
19 countries, is -- is what we're going to do about
20 selection bias. 12:33:31

21 Q I believe earlier you said that your view is
22 that the doctor's role isn't to recommend the treatment
23 for the minors who may be experiencing gender dysphoria
24 but, rather, to provide information to the parents and
25 the children and the parents and the children should 12:33:47

1 make the decision; is that fair?

2 A Yes. This is the idea that I am trying to
3 educate the world about, that, actually, doctors don't
4 know what the best treatment is for a particular child
5 and that they shouldn't pretend to know because there's 12:34:06
6 no follow-up data that are -- there's no compelling
7 follow-up data. There's just anecdotal reports like
8 you and I were just discussing. Or anecdotal reports.

9 And so given the fact that -- that people
10 believe doctors and they believe that doctors know 12:34:24
11 things and that I know doctors don't know things, you
12 see, what I'm saying, what I'm trying to influence the
13 world to think about is that we should make a -- we --
14 we recommend that you go to surgery for appendicitis
15 because we know the consequences of not having surgery. 12:34:44
16 You're going to die from this condition if you don't
17 have surgery, you see.

18 So we -- based on the consequences, we know
19 what is indicated medically to save life or preserve
20 function. 12:34:59

21 But in this particular area, the long-term
22 follow-up of children or adolescents or even adults who
23 undergo transition are not known. And I -- they're
24 not -- they're simply not known.

25 And because we are -- some doctors make 12:35:15

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1 recommendation to transition a seven-year-old or
2 transition a 14-year-old or remove the breasts of a
3 14-year-old, and I would say that what is the
4 scientific basis of your recommendation to tell
5 parents, who are often trusting of your knowledge base, 12:35:36
6 what is the scientific basis of your recommendation?

7 And I say, given what we know about science,
8 I'm not opposed to transitioning a child or
9 transitioning a teenager or an adult. What I'm saying,
10 that we should be able to educate, objectively, the 12:35:54
11 parents and the child themselves, you see, so that they
12 know the issues here.

13 And it's their child. They are legally
14 responsible and they're morally and ethically
15 responsible for the welfare of their child. And so I 12:36:11
16 think they need to be informed.

17 And -- and what I'm saying is, in the past,
18 doctors have recommended things, and I'm -- so I'm
19 questioning the wisdom of making a strong
20 recommendation because it's based on the allusion that 12:36:25
21 we know what is best for this kid or this adult. And
22 I'm saying, please, doctors, please be humble about
23 what your knowledge is here. Please respect the
24 limitations of your knowledge. That's all I'm saying.

25 So I -- I am objecting. I'm trying to teach 12:36:47

1 the world. If -- I know that sounds rather grandiose,
2 but I'm trying to teach the world that based on our
3 lack of information about the long-term follow-up, we
4 can give options for the treatment of this condition
5 and that option includes what you would call 12:37:03
6 affirmative care.

7 But we should understand the scientific basis
8 of affirmative care, you see, and we should understand
9 the limitations, and we should understand that even the
10 advocates of -- of gender-conforming surgery have 12:37:17
11 published two papers recently saying that the -- the
12 long-term psychosocial outcomes are not clear, that the
13 benefit of -- of -- of genital surgery or breast
14 surgery, in the long run, is not -- they're not clear.

15 And so people have undergone -- undertaken two 12:37:38
16 studies in the last year or two years to prove that
17 there are benefits. So why are we, in 2020 (sic),
18 doing studies to prove there are benefits if -- if we
19 already know the answer.

20 We don't know the answer. And I say because 12:37:56
21 we don't know the answer, there's an ethical
22 responsibility, a professional responsibility, to teach
23 the parents, teach the adult what is known and what is
24 not known.

25 What they decide is their business. It's 12:38:12

1 their prerog- -- it's their prerogative. It's their
2 child. It's their seven-year-old. It's not my
3 seven-year-old. See? It's not your seven-year-old.
4 It's not your 14-year-old. It's theirs. And it's a
5 weighted decision. And the idea that it's not a 12:38:25
6 weighted decision requires you to be an ostrich and
7 bury your head in the sand.

8 Q Do you think that politicians should be making
9 that decision?

10 MR. BROOKS: Objection. 12:38:36

11 THE WITNESS: Well, I -- I do ask myself the
12 question who should be making decisions about the
13 delivery of medical care, you see. And I do realize
14 that in some circumstances, politicians make decisions
15 that influence medical care and medical treatment. 12:38:55

16 I don't know the answer to that question, but
17 I don't know that doctors per se who are not informed
18 about the -- about the state of science really should
19 be making these decisions with the illusion that they
20 know best. I am not sure politicians know what's best. 12:39:16
21 I mean, when it comes to politicians, you know, we --
22 we all have skepticism.

23 But nowadays, what -- who is making decisions
24 are -- are judges, you see. I don't think juries as
25 much as judges and -- and state legislature and 12:39:35

1 governors are making decisions. I don't like that
2 either.

3 I would prefer that an informed medical
4 professional -- I would -- I would prefer that doctors
5 make these decisions based upon accurate scientific 12:39:54
6 information and not political ideology and not mixing
7 up civil rights concerns with medical decision-making.

8 So I realize we're in a -- this is a morass,
9 and I -- all I -- all -- my point to you today is let's
10 look at the science and let -- let the doctors decide 12:40:21
11 or let the politicians decide, let the governors
12 decide, let the judges decide, but on the basis of
13 science.

14 Q And are you aware of any scientific study
15 showing that affirmative care practitioners in the 12:40:40
16 United States are providing rapid affirmation, a
17 scientific study, not just anecdotal reports?

18 A There was a study out of the UK about 20 years
19 ago. I kind of think the author of the study was
20 M-O-L-E. I'm not certain. And they did a follow-up 12:41:10
21 study of people who were given sex reassignment surgery
22 immediately because they asked for it, with -- with
23 very little screening, versus people who were treated
24 as usual, because in that days, people had psychiatric
25 evaluation and psychotherapy, and I think they found in 12:41:33

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1 the small numbers of patients that they operated on
2 versus the people who weren't operated on, that there
3 seemed to be -- they seemed to be happier in the short
4 term after surgery than the people who didn't have
5 surgery.

12:41:49

6 But you know what I've been saying to you
7 in -- well, maybe I haven't quite said it yet. What
8 I'm saying is, when we come to evaluate the impact of
9 these treatments, we need to agree upon -- we have to
10 have a consensus, and it should be an international
11 consensus, about what is the ideal way to evaluate the
12 effects of these treatments.

12:42:07

13 Should it be, like, at six months, at
14 twelve months, should it be at six -- two years,
15 five years, ten years. And we should agree upon the
16 mecha- -- the measurements that we're going to use
17 prior to actually doing the study so that we all agree
18 upon both -- both the strengths and the limitations of
19 the methods.

12:42:28

20 So what I'm --

12:42:42

21 Q Yeah, maybe my question --

22 A What I'm trying to do is to refine the
23 requirements to answer your question.

24 Q Thank you. And I think maybe my question may
25 have been unclear.

12:42:55

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1 What I'm trying to figure out is that you've
2 testified about a perception that there's this
3 widespread practice of providing rapid affirmation
4 service in the U.S.; is that fair?

5	A	Yes, I do have that perception.	12:43:05
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6 Q And what I'm trying to figure out, is there
7 any kind of scientific or other -- otherwise kind of an
8 analysis of a -- of that healthcare market to determine
9 whether in fact that is actually happening or in fact
10 whether these are just anecdotal occurrences that 12:43:22
11 you've learned of?

12 A There -- your question is one of a series of
13 questions that I would have to answer as far as I know,
14 there are not -- there are not respected scientific
15 methods demonstrating my -- my impression. 12:43:44

16 Q Thank you. If you could turn to page --
17 paragraph 6 of your -- or it's probably on the same
18 page you have there, but I'm going to just ask a
19 question about paragraph 6 of your declaration -- or
20 your report. 12:44:02

21 And you talk about -- you can read the whole
22 thing. I'm not trying to misread it into the record,
23 but I wanted to focus on the sentence that says (as
24 read):

25	I have at one time or another	12:44:13
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1 recommended or prescribed or supported
2 social transition, cross-sex hormones,
3 and surgery for particular patients,
4 but only after extensive diagnostic
5 and psychotherapeutic work." 12:44:26

6 Do you see that?

7 A I do.

8 Q Have you ever recommended cross-sex hormones
9 for a minor patient?

10 A No. 12:44:37

11 Q Have you ever prescribed cross-sex hormones
12 for a minor patient?

13 A Is that a different question than you just
14 asked me?

15 Q Well, you have recommended or prescribed or 12:44:53
16 supported, and so I could go into asking you what the
17 difference is, but I just figured I'd ask you -- is
18 there a differences between recommended, prescribed and
19 supported?

20 A Oh, yes. I feel like my view of my role is to 12:45:08
21 write a letter of recommendation describing the patient
22 in detail, the -- the diagnosis, the patient's
23 sensibilities, whether I think this would be beneficial
24 to the patient at this time in his life.

25 The last person that I wrote, I was doing 12:45:26

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1 psychotherapy with a young person, starting at age 16,
2 and saw this person over the course of a year and a
3 half. I promised that if they continued talking to me,
4 at the end of the time, I -- if patient still wanted
5 hormones, I would give hormone- -- I -- I wrote a 12:45:47
6 letter of recommendation.

7 And I did write a letter of recommendation,
8 and the patient did take hormones. He went off to
9 college, failed miserably at college, transferred
10 college, and I sadly I tell you, and I -- I sadly tell 12:46:01
11 you, this person died of a heroin overdose in his dorm
12 room at Ohio State University.

13 And I know from the parents, postmortem, that
14 he acquired a girlfriend, and he then said that it's
15 not so bad -- he's rethinking this matter. It's not so 12:46:23
16 bad being -- being a male and having sex with someone.

17 But I don't know whether -- I -- his heroin
18 overdose, which was his third heroin overdose, was
19 accidental death or suicide.

20 So I have provided hormones. I do have that 12:46:40
21 really negative taste in my mouth from that experience.
22 I don't -- I don't -- I don't have remorse about giving
23 hormones to this person because I promised that if --
24 that it is his decision.

25 His parents weren't happy with that decision, 12:47:02

1 but they also agreed with the decision. And now
2 they're, of course, in perpetual mourning for their
3 deceased 18-year-old child.

4 So, yes, listen, I also have given hormones to
5 someone else who is living okay, who is not made any 12:47:20
6 suicide attempts. But it is, as I described in that
7 paragraph, after I get to know these people. And to
8 tell you, I -- as best as I can tell, they appreciate
9 that.

10 Q Thank you. I'm just -- sorry for the -- for 12:47:35
11 the person that you -- your -- your patient that you
12 mentioned, the -- the 18-year-old, I'm -- I'm sorry to
13 hear about that.

14 Sorry, when was that? What -- what time
15 period? 12:47:47

16 A That was --

17 Q Datewise.

18 A -- March 17th, 2021.

19 Q And did you prescribe the -- or, sorry, write
20 a letter for the hormones before the person was 18 or 12:47:58
21 only once they were 18?

22 A I think the person turned 18 in August or
23 September, and I think I wrote the letter right near
24 the person's birthday. Whether it was before or after,
25 I'm not sure. 12:48:19

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1 Q How about social transition, have you ever
2 recommended or prescribed or supported social
3 transition for a minor?

4 A A minor being someone less than 18?

5 Q Correct. 12:48:34

6 A Have I ever recommended, prescribed -- I have
7 never prescribed. I have met people who already had
8 social transition, and I had supported them even in the
9 face of their parents' objection. But I don't think I
10 have ever prescribed social transition to a person. I 12:49:00
11 cooperate with it. I recognize that -- I recognize
12 that it is the patient's decision. And while I may not
13 have thought it was a wise decision to transition or to
14 surreptitiously take hormones, you know, from China or
15 something, I -- I don't interfere with it. I just talk 12:49:30
16 about it.

17 So -- but if you're really asking have I said,
18 oh, Parents, you should transition your child, I think
19 the answer is no.

20 Q Yeah. So I'm trying to -- that's -- thank you 12:49:43
21 for clarifying that. I -- I'm trying to figure out if
22 you've supported the transition of a -- the social
23 transition of any minor patients.

24 A Yes.

25 MR. BROOKS: Objection; vague. 12:49:53

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1 BY MS. HARTNETT:

2 Q When was the last time you supported the
3 social transition of a minor patient?

4 A Two years ago, I'm guessing.

5 Q Okay. Let me -- do you know who B.P.J. -- 12:50:08
6 B.P.J. is the plaintiff in this case.

7 Do you know if B.P.J. is a girl or a boy?

8 A I know nothing about B.P.J.

9 Q So you've reviewed none of her medical records
10 or anything like that? 12:50:32

11 A Yeah, I would presume that this is a trans
12 boy -- a trans girl who was born a -- a boy, but I
13 wouldn't -- I have no certainty.

14 Q What makes you presume that?

15 A Well, because trans -- trans girls 12:50:47
16 generally -- I mean -- how should I say it? Trans
17 girls -- trans adolescent girls generally don't -- wait
18 a -- I'm getting confused here. Excuse me.

19 I presume that B.P.J. is an -- was born and
20 assigned and is a natal -- was a natal male. 12:51:17

21 But if it's a natal female, I -- I've not
22 heard anything where a natal female becomes a trans boy
23 and wants to compete against boys. If there is a
24 lawsuit like that, that has been raised, I am unaware
25 of it. 12:51:43

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1 When I read these things in the newspaper,
2 it's -- it's -- they're -- they're always about natal
3 boys who live as trans women or girls and want to
4 compete against women. So that's why I presume that
5 B.P.J. must be a natal male. 12:52:04

6 But because my role in this case had nothing
7 to do with the athletic side, it's just to -- to
8 provide some basis of -- some background basis on the
9 science of transgender knowledge and the lack of
10 knowledge, I didn't spend time investigating that. 12:52:23

11 Q Okay. And are you familiar with the law
12 that's being challenged in this case that's called
13 H.B. 3293?

14 A No.

15 Q Could we just turn to page 20 of your 12:52:42
16 declaration, paragraph 50 -- or your -- sorry, I'm
17 saying declaration. I mean report.

18 MR. BROOKS: We're getting there.

19 MS. HARTNETT: No, take your time. Page 20,
20 paragraph 50. 12:53:00

21 MR. BROOKS: Let's see. This is under -- just
22 simply -- since I can't fit it all on the screen at
23 once, it's under the heading that says, "The
24 affirmation therapy model (model #4)." And now, under
25 that, I have paragraph 50 showing on the screen. 12:53:14

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1 MS. HARTNETT: There is a way to, I believe,
2 make that -- I don't know if he needs that to be that
3 large to read it, but there is -- if you hover over the
4 document, you can zoom in or out.

5 MR. BROOKS: Perhaps. But this is, I think, 12:53:31
6 much smaller, and it would be hard to read.

7 THE WITNESS: I have the entire paragraph 50
8 in front of me.

9 BY MS. HARTNETT:

10 Q Okay. Thank you. 12:53:41

11 So I was looking through your report, trying
12 to see if there was a connection to the context here,
13 which is this sport -- whether the plaintiff can play
14 sports, and I'm just looking -- you can look at all of
15 paragraph 50, if you need to, but I'm going to be 12:53:51
16 focused on -- well, feel free to take a look.

17 But you're -- under this part called "the
18 affirmation therapy model." That's the heading that's
19 above paragraph 50.

20 Do you see that? 12:54:04

21 A Yes.

22 Q And you're referring to -- what -- you say
23 that -- you're referring to some advocates and
24 practitioners that go much further. That's in your
25 second line there. And then I'm going to just read one 12:54:14

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1 sentence in the middle of the paragraph. (As read):

2 "They argue that the child should be
3 comprehensively resocialized in grade
4 school to (sic) their aspired-to
5 gender. As I understand it, this is
6 asserted as a reason why male students
7 who assert a female gender identity
8 must be permitted to compete in girls'
9 or women's athletic events."

12:54:27

10 Did I read that correctly?

12:54:37

11 A Yes, you did.

12 MR. BROOKS: And I will -- well, you can ask a
13 question. I'm going to ask the witness to read the
14 entire paragraph so we don't lose the --

15 MS. HARTNETT: He should feel free. I'm
16 not -- this is not a trick.

12:54:50

17 MR. BROOKS: Nope.

18 BY MS. HARTNETT:

19 Q Let me know when you're ready.

20 A I've read the paragraph.

12:55:22

21 Q Do you know whether the law being challenged
22 in this case applies to grade school?

23 A I don't -- I don't know the law being
24 challenged here.

25 Q So you don't know whether the law at issue

12:55:35

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1 requires that transgender youth be comprehensively
2 resocialized; is that fair?

3 MR. BROOKS: Objection.

4 THE WITNESS: When I talk about
5 comprehensively resocialized, it was not in 12:55:51
6 relationship to this law; it was in relationship to the
7 American Academy of Pediatrics' recent study, I think
8 in 2018, by Rafferty, et al., where it was asserting --
9 they were asserting such things that I'm summarizing
10 here. 12:56:18

11 And, see, for them, participation in athletics
12 just follows their fundamental assumption that they
13 know what's best for these children even though they
14 have no long-term -- they don't even have adolescent
15 follow-up, let alone adult follow-up. 12:56:35

16 And so I just think that the case of
17 athletics -- the issue of athletics is a secondary
18 derivative issue about the more fundamental matter of
19 when and how, to what extent, and before -- what
20 requirements are necessary before we socialize a child, 12:56:55
21 you see.

22 So if you think about the -- your issue today
23 about athletics, it's what I would call a downstream
24 issue, downstream from the fundamental thing that we
25 were talking about before the last break about what are 12:57:15

1 the requirements to ethically enable parents to make
2 this decision without doctors pretending like they know
3 what's best for a seven-year-old or an eight-year-old
4 or a 12-year-old or a 15-year-old, you see.

5 So this is a downstream question about which I 12:57:34
6 feel I have no legitimacy to pretend expertise.

7 So I think every question you ask me about
8 this, I'm going to have to say, listen, this is not
9 my -- this is not my wheelhouse. This is not my
10 knowledge base. My knowledge base is about what we 12:57:54
11 were talking about, you know, about the evaluation of
12 children and teens.

13 BY MS. HARTNETT:

14 Q So here, where you say, "this is asserted as a
15 reason why male students who assert a female gender 12:58:07
16 identity must be permitted to compete in girls' or
17 women's athletic events," when you say -- asserted by
18 whom? Is it the American Academy of Pediatrics? Is
19 that who you're referring to there?

20 A No, I don't think it's entirely that. I think 12:58:23
21 it has to -- you know, this is a -- this is a big
22 cultural issue in many, many states. They made -- the
23 NCAA, you know, the high school athletic associations,
24 whatever the names, the acronyms of those
25 organizations, they have made policies based upon 12:58:48

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1 information that they've gotten from various, quote,
2 expert groups, and -- and there is this -- in education
3 services today, there is this enormous emphasis on
4 diversity and support for all forms of diversity, and
5 so I -- I think the answer is not it's just from the 12:59:12
6 American Academy of Pediatrics. I think the American
7 Academy of Pediatrics is influenced by these larger
8 social trends that have recognized how much harm we've
9 done to various -- to women, for example, or to African
10 Americans or to Asians, and we are trying, as a 12:59:34
11 society, to make things more open and to -- to
12 represent more people in the public discourse in arts,
13 in music, in the theater and so forth.

14 So there's just a broad, broad cultural trend
15 towards being much more inclusive, you see, and -- and 12:59:52
16 I just think the trends -- athletic issue must be
17 viewed in terms of the larger social questions that are
18 being answered in a political sense in our culture.

19 MR. BROOKS: Counsel, when you get to a
20 breaking point, I think it is one o'clock, and it would 01:00:10
21 be a good time to take a lunch break.

22 MS. HARTNETT: We can break now. I have a
23 couple more questions on this paragraph, but we can
24 pick it up after lunch. What would you prefer?

25 MR. BROOKS: You can finish up the paragraph. 01:00:27

1 MS. HARTNETT: Sure.

2 BY MS. HARTNETT:

3 Q So -- so is it your view that allowing a
4 transgender youth to participate on the team of
5 their -- the sex that they present as, is that a 01:00:39
6 psychotherapeutic intervention that would dramatically
7 change the outcome for that child?

8 A I'm not certain.

9 Q What is your concern -- I'm sorry, please.

10 A I think if -- I think if a child, let's say a 01:01:02
11 14-year-old, wants to run track or play a sport as a
12 member of a female -- the female side of the sport and
13 if the school or the -- the State or the -- the
14 organization that -- that organizes high school
15 athletics or junior high school athletics says, no, you 01:01:31
16 can't because you were a natal male and you -- trans is
17 not accepted as -- for athletic purposes, I think that
18 person would be disappointed. I think that would be
19 disappointed. And disappointment may look like
20 depression. It may increase the person's anxiety for a 01:01:52
21 while. But like many, all of us get disappointed in
22 life, and, you know, we deal with it. And sometimes we
23 grow from our disappointment.

24 So I would think they would be disappointed.

25 Whether that is to be considered harm, you see, I don't 01:02:12

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1 think we would -- we should, just on the basis of
2 disappointment, refer to that as harm. Harm is a
3 different concept, you see.

4 And -- so I guess the answer to your question
5 is I'm not sure. 01:02:32

6 Q But do you think that permitting them to play
7 with -- in that example, allowing the 14-year-old
8 person that identifies and is a girl to play with the
9 girl team, do you believe that that would make them
10 more likely to continue to identify as transgender when 01:02:50
11 they otherwise would not?

12 MR. BROOKS: Objection; ambiguous.

13 THE WITNESS: They would otherwise continue --
14 you -- you mean -- if I understand --

15 BY MS. HARTNETT: 01:03:05

16 Q I'm sorry, I'll ask a better questions.

17 I'm just trying to figure out if your opinion
18 is that allowing transgender, let's just say,
19 adolescents to play on sports teams that match their
20 gender identity will cause them to continue to identify 01:03:15
21 as transgender when they otherwise would not.

22 A I have no idea the answer to that question. I
23 would imagine that they would continue to identify as a
24 trans female, but I don't know what would happen to
25 their identity if they didn't. That was the other side 01:03:40

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1 of your question, the last part of your questions.

2 So I guess I can answer part of the question.

3 It would be my opinion, if we allowed a child
4 who currently identifies as a trans girl to participate
5 in a girl's athletic -- organized athletics, that that 01:03:57
6 would do nothing -- that would -- that would reinforce
7 the idea that she continues -- that she is a trans
8 girl. Not that she is a girl, but that she's a trans
9 girl. That's -- I think that would be my opinion.

10 About the other aspect to your question, I 01:04:20
11 don't know the answer.

12 Q But is your opinion that there's a -- is that
13 a -- in your opinion, is there something wrong with
14 reinforcing the girl being on -- sorry -- the girl's
15 gender identity of being on the team? 01:04:33

16 Like, do you have a problem with that, or are
17 you okay with the 14-year-old girl playing on the --
18 transgender girl playing on the girls' team if the
19 rules allow it?

20 MR. BROOKS: Objection; vague, compound. 01:04:42

21 THE WITNESS: If you -- if you look narrowly
22 at the individual girl, we get one set of
23 considerations.

24 If we look at fairness, if we look at the
25 perspective of the other girls, the natal girls who are 01:05:07

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1 participating, we get another perspective.

2 If we look at the parents' perspective of the
3 very talented athletes who are natal girls who may be
4 defeated by these trans girls, we get yet a third or
5 fourth perspective. 01:05:31

6 BY MS. HARTNETT:

7 Q Well, that's not your area of expertise;
8 correct?

9 A But you -- you just anticipated what I was
10 going to say. I mean, you're asking me opinions that I 01:05:39
11 have no legitimate expertise to answer. I -- I'm
12 just -- I'm separating the perspectives for you. And I
13 say your -- your question is not as simple as it
14 sounded because there are these other perspectives to
15 be considered which people other than me are going to 01:05:57
16 consider.

17 There is -- shall I repeat?

18 There is the child --

19 Q No, I don't think so. I don't think you
20 should repeat. But what I do -- would like would be 01:06:08
21 before we have lunch, just an answer, which is do you
22 object --

23 MS. HARTNETT: Can you -- can the reporter
24 read back my last question, please.

25 THE REPORTER: Yes. 01:06:15

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1 (Record read.)

2 MR. BROOKS: Objection; compound, form of the
3 question, vague.

4 You can answer, if you are able and know what
5 the question is. 01:07:02

6 MS. HARTNETT: That's -- enough coaching.

7 THE WITNESS: Pardon me? I didn't hear what
8 you just said.

9 BY MS. HARTNETT:

10 Q I was telling your counsel to please stop 01:07:07
11 coaching you. And I can ask a better question.

12 A Oh.

13 Q Is it your perspective that allowing a
14 transgender girl to participate on a girl team,
15 consistent with her gender identity, is harmful to the 01:07:18
16 transgender girl?

17 A No, I don't think it's harmful in the short
18 run to the transgender girl. In the long run, if the
19 transgender girl detransitions, say, in five years, I
20 wonder what he will now think about what happened five 01:07:36
21 years before when she was competing against girls as a
22 girl.

23 But in the -- I presume your question is in
24 the short term, you see? And I guess in the short
25 term, I don't think it would harm the child to the 01:07:58

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1 extent that it reinforces their current identity.

2 But as you may or may not know, gender
3 identity can evolve over time. And so when people
4 detransition and return to presenting themselves as a
5 boy and thinking of themselves as a boy, they then have 01:08:20
6 to -- they then have to consider what happened when
7 they were -- when they were presenting themselves as a
8 girl and believing that they were a girl. They no
9 longer believe that they're a girl, but they did back
10 then, you see? 01:08:39

11 So I don't know, I don't think anybody knows,
12 what implications, what harm, might come from their --
13 what retrospective view of the harm that -- that they
14 cause themselves by presenting -- by competing against
15 girls. So -- 01:08:58

16 Q Does anybody know the implications of the
17 disappointment that the transgender girl might
18 experience from exclusion, or is it similarly
19 indeterminant?

20 MR. BROOKS: Objection. 01:09:09

21 THE WITNESS: Well, I -- I think I've already
22 answered the question, that disappointment -- I would
23 expect it if a -- if the girl -- the trans girl wanted
24 to participate and was prohibited by some larger force
25 from participating, they would be disappointed, and it 01:09:24

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1 may have -- it may have -- it -- and I couldn't predict
2 the outcome of the disappointment, whether it would
3 precipitate depression or whether it would precipitate
4 giving up their trans identity, as being unrealistic,
5 that other people are saying I am very unrealistic 01:09:47
6 and -- and this is unfair and I'm asking for an unfair
7 advantage.

8 So, you know, I can't -- I don't -- these are
9 not areas that I -- that anyone has had any experience
10 with, you see. And -- and I -- it's hard for me to 01:10:01
11 give you a simple answer.

12 It feels to me, Ms. Hartnett, that you are
13 trying to get me to answer a question in a certain way,
14 and I'm just trying to say I think it's more
15 complicated. And I think you're asking me to give an 01:10:16
16 opinion about which I don't have adequate knowledge,
17 and I don't -- that's all. Period.

18 Lunch.

19 MS. HARTNETT: Let's go to lunch.

20 THE VIDEOGRAPHER: We are off the record at 01:10:35
21 1:11 p.m.

22 (Lunch recess.)

23 THE VIDEOGRAPHER: We are on the record at
24 2:11 p.m.

25 MS. HARTNETT: Thank you. 02:11:22

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1 BY MS. HARTNETT:

2 Q Welcome back, Dr. Levine.

3 I think before the break, we had -- I'm not
4 sure what page you have up, but I -- I'm at
5 paragraph 50 of the declaration.

02:11:31

6 A So are -- so am I.

7 Q Okay. Let's -- I was trying to -- and the
8 reason why we were talking about that is there was a
9 mention of athletic events there, and the other mention
10 of athletic events in your declaration is at
11 paragraph 130. So if you could go to 130, I'll have a
12 question about that.

02:11:43

13 Let me know when you get to 130, please.

14 MR BROOKS: We are at 130, which fits on the
15 screen.

02:12:14

16 BY MS. HARTNETT:

17 Q Great. So here in this paragraph, you say, in
18 the third sentence, the following (as read):

19 "It is evident from the scientific
20 literature that engaging in therapy
21 that encourages social transition
22 before or during puberty—which would
23 include participation on athletic
24 teams designated for the opposite
25 sex—is a psychotherapeutic

02:12:26

02:12:37

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1 intervention that dramatically changes
2 outcomes."

3 Do you see that?

4 A I do.

5 Q And you don't know if H.B. 3293 applies to 02:12:46
6 prepubertal kids; right?

7 A I'm sorry, would you repeat that question.

8 Q You don't know if H.B. 3293 applies to
9 prepubertal kids?

10 A I already testified that I don't know the 02:13:03
11 content of the deal.

12 Q So is it your opinion that allowing
13 transgender children and adolescents to play on sports
14 teams will continue -- will cause them to continue to
15 identify as transgender? 02:13:21

16 A I think it -- well -- well, you know, my
17 hesitance is because you used the word "cause."

18 Q I'm just trying to --

19 A A child --

20 (Simultaneous speaking.) 02:14:10

21 BY MS. HARTNETT:

22 Q Oh, sorry, go ahead.

23 A That's why I have taken so long. I'm -- I'm
24 thinking about the word "cause" and its implications in
25 my mind. I -- I do think that various aspects of 02:14:20

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1 social transition tend to continue the child on a life
2 course consistent with trans life, whether or not
3 they're aware of the risk that they're entailing or
4 not.

5 I think that's as close to an answer I can 02:14:45
6 give you.

7 Q Are you aware of any research indicating that
8 by preventing children from playing on sports teams
9 consistent with their gender identity that will prevent
10 them from continuing to identify as transgender going 02:14:59
11 forward?

12 A I'm not aware of research literature about
13 athletic teams and its impact, positive or negative, at
14 all. I'm totally unaware.

15 Q Okay. Do you think that by excluding 02:15:14
16 transgender girls from playing on the girls' team the
17 law that's being challenged in this case stigmatizes
18 transgender girls?

19 MR. BROOKS: Objection.

20 THE WITNESS: I think it may disappoint 02:15:48
21 transgender girls. Stigma has another concept. You
22 know, it has to do with social things.

23 I -- I think a reasonable mental health
24 professional could assume that if a child wanted
25 something and was prohibited from it, they would be 02:16:03

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1 disappointed, at least initially.

2 Other than that, I -- I don't care to comment.

3 BY MS. HARTNETT:

4 Q Well, say a child wants a cookie and they
5 aren't allowed to have it. That's disappointing; 02:16:23
6 right?

7 A Yes.

8 Q Is the disappointment that a transgender child
9 would have from being excluded from a sports team
10 consistent with their gender identity essentially that, 02:16:31
11 equivalent of the cookie denial?

12 MR. BROOKS: Objection; calls for speculation.

13 THE WITNESS: I don't know if you even put my
14 smile into the text.

15 Obviously, you know, there -- there are 02:16:57
16 degrees of disappointment in the universe. And to
17 equate that with a cookie, I don't know. I prefer not
18 to even answer that question.

19 BY MS. HARTNETT:

20 Q Well, your -- your point of view is that 02:17:10
21 people that experience being transgender also generally
22 experience a wide range of other distressing feelings
23 and conditions; correct?

24 A My point of view is what?

25 Q That people who are transgender also 02:17:27

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1 experience a wide range of other concerns and -- and
2 issues; correct?

3 A Yes, I think -- yes.

4 Q That they're subject to serious mental health
5 issues, that's your point of view; correct? 02:17:47

6 A I think they're apt to encounter a number of
7 frustrations in their future lives that could add to
8 their social anxiety, their sense of pervasive sadness
9 and it lead to solving the problem in ineffective ways,
10 like substance abuse. 02:18:13

11 So, yes, I do think that being transgender,
12 for -- for many, many people, poses adaptive challenges
13 in the present and in the future.

14 Q How do you know that that's based on being
15 transgender as opposed to how the transgender people 02:18:34
16 are being treated, or do you not distinguish between
17 the two?

18 A Because -- because some of the -- in children,
19 some of the psychiatric problems that they have are --
20 occur well before there's any awareness of the society. 02:18:54

21 And in every cross-sectional study of adults
22 in the transgender community have shown that the --
23 that they're a vulnerable population and they're
24 vulnerable to many psychiatric difficulties, and the
25 common explanation for that, among trans advocates, is 02:19:19

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1 that it's entirely due to social discrimination whereas
2 I think if you look at the premorbid and the
3 accompanying psychiatric difficulties of many trans
4 people, these -- these -- the social discrimination has
5 only added to the -- the internalized conflicts about 02:19:37
6 what they're doing.

7 So I think it's far more complicated than it's
8 merely a result of stigma, so to speak.
9 "Discrimination" would be a better word, I guess.

10 Q Yeah, I'm -- thank you. And I'm trying to 02:19:54
11 reconcile that view with the notion that excluding a
12 transgender youth who, in your view, might be subject
13 to these various preexisting psychological problems,
14 why -- where you're having -- where -- what is the
15 basis for you believing it would just be a simple 02:20:09
16 source of disappointment for the trans youth to be
17 excluded from a team, consistent with their gender
18 identity, as opposed to a more severe harm?

19 MR. BROOKS: Objection.

20 THE WITNESS: Number one, I don't think 02:20:22
21 there's any research in this area. So whatever --
22 whatever you would like to conclude, I think there's no
23 basis for it.

24 I'm just trying to understand, based on my
25 knowledge of human beings, that for one person, it 02:20:37

1 would be a major disappointment and it might lead to
2 harm for that person, and for another person, it might
3 be a major disappointment that leads to no harm, and
4 for another person, it might be, oh, well, so what, and
5 it's not a big -- not a big deal. 02:20:52

6 Every study of human beings shows the variety
7 of human beings. And we can't predict that if you
8 exclude a child from anything on the basis of their
9 gender identity, that it's going to cause --
10 automatically, you can guarantee it will cause harm. 02:21:12
11 There's just no reason to think that.

12 It doesn't mean there isn't a child who might
13 not be harmed, but it doesn't mean that all the
14 children will be harmed, and it doesn't mean that the
15 harm will follow in the same manifestation. 02:21:27

16 Human beings have a variety of responses to
17 everything.

18 BY MS. HARTNETT:

19 Q So is your view for the trans girls that would
20 be excluded under a policy of not allowing them to play 02:21:43
21 on the team consistent with their gender identity, that
22 they should just toughen up and stomach the
23 disappointment?

24 MR. BROOKS: Objection.

25 THE WITNESS: You're putting words in my 02:21:55

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1 mouth. That's not my view. That's not how I was --
2 that's not how I have spoken about it. You're
3 summarizing it in a very negative way for me. I don't
4 accept your language. It's not me.

5 BY MS. HARTNETT: 02:22:09

6 Q Okay. You don't have to.

7 How would you put it?

8 A I already put it.

9 MR. BROOKS: Objection.

10 BY MS. HARTNETT: 02:22:15

11 Q You mentioned before the break that you also,
12 in your view, had to look at the potential harms or the
13 effects on the other people at issue, and I think you
14 mentioned the other girls on the team; is -- did I hear
15 you right? 02:22:26

16 A I think I did mention that.

17 Q Are you giving an expert opinion in this case
18 about the harm to girls on a team where they would have
19 to include a transgender girl?

20 A I don't know how many times, Ms. Hartnett, I 02:22:41
21 have to tell you that I don't consider myself having an
22 expert opinion on this subject. I have stated what I
23 stated, but I don't -- I don't -- I don't feel like I
24 represent an expert.

25 And so the answer to your question is, no, I 02:22:59

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1 don't have an expert opinion on that.

2 Q Thank you. I have a few questions about your

3 expert report. I'm just going to go back to the

4 beginning and go through sequentially, and I'll --

5 please feel free to read the paragraphs I cite to you 02:23:16

6 while I'm asking you questions.

7 My first one is going to be back on

8 paragraph 5, page 2.

9 MR. BROOKS: Getting there.

10 Paragraph 5 is on the screen. 02:23:36

11 MS. HARTNETT: Yeah, we were there before.

12 BY MS. HARTNETT:

13 Q I just had a question about -- so I was

14 comparing this report to the declaration that was

15 submitted at the beginning of the case. That was the 02:23:47

16 one from the Washington State declaration that had been

17 attached to an earlier motion in the case. And that's

18 something I introduced as Exhibit 86. So if you need

19 to refer to it, feel free.

20 But I will just represent to you that in the 02:24:02

21 version of paragraph 5 that was in your earlier

22 declaration, you had certain language that's no longer

23 in this report. I'll read it to you and then -- just

24 curious as to why you removed it.

25 You -- this is the declaration that you signed 02:24:15

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1 in May of 2021. (As read):

2 "As the incidence of gender dysphoria
3 has increased among children and youth
4 in recent years, larger numbers of
5 minors presenting with actual or
6 potential gender dysphoria have
7 presented to our clinic.

02:24:29

8 I currently am providing psychotherapy
9 for several minors in this area. I
10 also counsel distressed parents of
11 these teens."

02:24:41

12 Do you know why you removed that language from
13 your -- this report?

14 MR. BROOKS: And, counsel, are -- asking that
15 question, are you representing that that or similar
16 language doesn't appear somewhere else in the report?

02:24:54

17 MS. HARTNETT: I was unable to find that
18 language in this report. It was in paragraph 4 of the
19 PI declaration, which is now paragraph 5 of this
20 report, and I was not able to find that language.

02:25:09

21 THE WITNESS: I would imagine the answer to
22 the question is I didn't think it was relevant to this
23 particular document.

24 Please understand, in preparing this document,
25 I did not read the -- Exhibit 86.

02:25:29

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1 BY MS. HARTNETT:

2 Q Is it true that larger numbers of minors have
3 been presenting with actual or potential gender
4 dysphoria to your clinic?

5 A No. It's true that across the world larger 02:25:46
6 numbers of minors are requesting services for gender.
7 That's an epidemiologic phenomenon that exists on four
8 continents.

9 Q Is it true that you are currently providing
10 psychotherapy for several minors in this area? 02:26:07

11 A Yes.

12 Q How many?

13 A It depends on what era you're -- what month,
14 what week, what -- what year you're talking about. If
15 you're talking about within the last year, I would say 02:26:22
16 probably four or five kids.

17 Q Can you give me the ages of those kids?

18 A Probably from 14 to 17.

19 Q And how many of those have you seen more than
20 one time? 02:26:41

21 A Each of them.

22 You should -- well, okay.

23 Oh, one of them I've seen once, I'm sorry.

24 I -- let me correct that.

25 Q For the other four, do you see them on a 02:27:01

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1 monthly basis?

2 A No. I -- I tend to see them more often.

3 Q Are there any of those patients that you have
4 seen on a monthly or less basis, other than the one you
5 only saw once?

02:27:21

6 A Well, I hear from patients I see in the past
7 periodically, sometimes. I hear from their parents. I
8 sometimes hear from them. But it's -- it's not
9 anything regular.

10 Q Yeah, I'm -- thank you. I'm just trying to
11 understand. There was a statement made in your
12 May 2021 declaration that you were currently providing
13 psychotherapy for several minors in this area, and I'm
14 just trying to figure out, is that actually true today?

02:27:45

15 A No, it's not true today to the same extent
16 that it was when I wrote the original -- the Tingley
17 declaration.

02:27:59

18 Q Thank you. Moving down in here, you have on
19 page -- paragraph 7 and paragraph 8, you identify a
20 couple of cases where you previously provided
21 testimony.

02:28:15

22 A Yes.

23 Q There's the -- the case in the Eastern
24 District of Massachusetts, in the First Circuit, that
25 you refer to in paragraph 7.

02:28:29

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1 Do you see that?

2 A Yes.

3 Q And then there's the Younger litigation in
4 paragraph 8.

5 Do you see that? 02:28:37

6 A Yes.

7 Q And you do cross-reference your CV list and
8 then the Tavistock case.

9 Do you see that?

10 A Yes. 02:28:47

11 Q Why did you choose to highlight the
12 Massachusetts and the Younger case here?

13 A Well, the Massachusetts case, under
14 Judge Wolf, Judge Wolf asked me to be a judge's
15 witness. That was the beginning of my legal 02:29:10
16 involvement in that whole area of transgenderism. So I
17 think that that's noteworthy. It's also noteworthy
18 because that became -- among the DOC attorneys across
19 the nation, that's a very landmark case, and it's often
20 quoted in various other legal matters. 02:29:29

21 So it seemed to me that you ought to know that
22 I began in that area in 2006 with Dr. -- with
23 Judge Avery.

24 And what was the second part of your question?

25 Q Oh, the Younger case and why you included that 02:29:49

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1 here.

2 A I included that because that was my entry case
3 into transgender children and the -- when parents don't
4 agree on the treatment of their trans child and -- and
5 courts are involved and -- I mean, that is not just 02:30:10
6 happening in the Younger case. That's happening in
7 other jurisdictions as well. And so I --

8 Q In the Younger -- oh, sorry.

9 A That that's the kind of thing you wanted to
10 know. That is a credential, in a sense. Or I thought 02:30:26
11 that you would like to read that case, if you could.

12 Q Are you aware the jury rejected the father's
13 claim in the Younger case and awarded the
14 decision-making to the mother?

15 MR. BROOKS: Objection; mischaracterizes the 02:30:43
16 record.

17 THE WITNESS: One of my complaints about my
18 participation is I -- I often am not informed about the
19 outcome and the progress of the cases that I've
20 testified in. 02:30:55

21 I did -- I did hear something like you --
22 what -- what you said, but it seems to me that it was a
23 more complicated decision than you summarized.

24 BY MS. HARTNETT:

25 Q Are you aware that -- of the more recent 02:31:14

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1 litigation in Texas regarding a directive from the
2 attorney general about the investigation of the --
3 sorry -- by the directive of state officials to
4 investigate those providing transgender care for child
5 abuse? Does that ring a bell? 02:31:30

6 MR. TRYON: Objection.

7 THE WITNESS: I only know about that because I
8 read it in the papers. I have not --

9 BY MS. HARTNETT:

10 Q Okay. That's what I was going to ask you. 02:31:40

11 Were you involved in that? Were you asked to
12 provide an expert opinion in that case?

13 A Never.

14 Q Is there a reason why you didn't include the
15 Nosewor- -- Norsworthy case when you were summarizing 02:31:50
16 your background here in paragraph 7 and 8?

17 A The Noseworthy case is one of, I don't know,
18 seven or eight cases. I -- if you look at my CV, I'm
19 sure it's listed in my CV.

20 This is a prisoner case. I didn't think it 02:32:22
21 had to do with -- it just didn't seem it had to do with
22 athletics and -- and teenagers.

23 Q Are you aware that your testimony was
24 partially excluded in a case called Claire in Florida
25 that was about the -- it was precluded with respect to 02:32:40

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1 the testimony about the motivations that plaintiffs had
2 for seeking gender confirmation surgery.

3 A I was not --

4 MR. BROOKS: Objection.

5 THE WITNESS: I was not aware. 02:32:51

6 BY MS. HARTNETT:

7 Q Just flashing forward to paragraph 13 here.
8 This is a paragraph where you're discussing, in part,
9 Dr. Adkins' declaration. And my first question is, at
10 the end of this paragraph, you talk about a life course 02:33:15
11 perspective?

12 A Yes.

13 Q I'm just curious if that's a term that you
14 coined or that's from somewhere else in the literature.

15 A If I took credit for coining that term, I 02:33:36
16 think it would be -- I didn't -- I didn't coin the term
17 "life perspective."

18 I'm a -- I'm a psychiatrist, and I see people
19 throughout the life cycle, and so I am constantly
20 confronted with the consequences of early life 02:33:54
21 decisions and of behavioral patterns.

22 I have a natural life perspective on matters.
23 I certainly didn't -- I don't believe I coined the
24 term.

25 Q Well, I ask because it's in quotes, and so I'm 02:34:10

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1 just wondering if it's something that you refer to your
2 method as the life course perspective or if that's a
3 method I could look to in the literature somewhere.

4 A I think it's in quotes -- I think it's in
5 quotes because I wanted to emphasize the perspective 02:34:25
6 that this whole question about how to take care of
7 trans youth needs to be understood, not does it make
8 them happy in the current life, but what will it do to
9 the whole course of their life.

10 And so by putting it into italics (sic), I -- 02:34:46
11 I -- perhaps -- perhaps I shouldn't have done that, but
12 I was just trying to bring the reader's attention to
13 the perspective here that the decisions that are made
14 in teenage years, for example, or in their 20s or in
15 their 30s have implications, serious implications, for 02:35:08
16 10 years, 20 years, 30 years down the pike.

17 And as an adult psychiatrist who deals with
18 people, you know, from 96 down, I certainly see the
19 impact of previous life decisions on their current
20 suffering. 02:35:32

21 And so that's all it refers to, that -- and I
22 do believe that if you spend your time in pediatrics,
23 you probably don't have as -- as sharp a focus on the
24 life perspective that an adult person -- adult -- a
25 per- -- specializes in adults or who has a lot of 02:35:50

1 experience with adults have. That's all I'm trying to
2 say.

3 Q Is it your view that Dr. Adkins' approach is
4 to make the young person happy as opposed to creating a
5 happy, high-functional, mentally healthy person for the 02:36:06
6 next 50 to 70 years of life?

7 A I believe that Dr. Adkins has hope that she is
8 going to create a happy, functional human being for the
9 next 70 years of life, but I do believe she's
10 influenced, primarily, on making her child -- her 02:36:20
11 current patients happy.

12 The question is does Dr. Adkins have any
13 evidence whatsoever that the decisions that she has
14 been making with teenagers and younger children,
15 does -- does she know that creates happiness in ten 02:36:38
16 years or in five years. And certainly, I don't think
17 she knows what happens in 30 years.

18 But I think as a society, you and I as
19 representatives of society, can recog- -- recognize the
20 relevance of the question. 02:36:56

21 We want to separate, at all times, physicians'
22 beliefs from the evidence that supports those beliefs.

23 Q What's the basis for your notion that
24 Dr. Adkins lacks an understanding of how to create a
25 happy, highly functional, mentally healthy person for 02:37:15

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1 the next 50 to 70 years of life?

2 A Because she's a pediatric endocrinologist.
3 Because she's a busy person dealing with young people.
4 Because she doesn't follow-up her patients, I'm sure,
5 for 30 years. 02:37:31

6 Q Do you follow-up your patients for 30 years?

7 A Some of them, yes. You know I published a
8 paper about a 30-year follow-up of a trans person.
9 Maybe you don't know. I published a paper about
10 returning to the male gender role after 30 years. 02:37:48

11 Now, I can't say that I have, you know, 20
12 patients I've followed for 30 years, but I -- I have
13 certainly written about that case, and in -- in writing
14 about that case, I have raised certain issues that are
15 germane to your questioning right now. That is, a life 02:38:05
16 perspective, a life course perspective is something
17 that's reasonable and that an educa- -- a physician
18 needs to be thinking about the long-term outcome of
19 what is being done today.

20 Q What is the basis for you -- but you're -- 02:38:24
21 sorry, I think you've already stated it, but I -- is
22 there any other reason you have to believe that
23 Dr. Adkins is not informing herself about the
24 consequences of her actions on her patients 30 --
25 30 years from today? 02:38:39

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1 A Only that she could not know what happens.
2 She hasn't been practicing 30 years, I don't believe.
3 And I don't believe she is in a position, considering
4 the work that she does, to have systematic follow-up,
5 even for shorter periods of times, on her patients. 02:38:54

6 If, for example, she has systematic follow-up
7 on 80 percent of the patients she's ever given a
8 hormone treatment for, that should be in the
9 literature. And she knows, she should know, given
10 the -- the -- what's absent from the literature, how 02:39:15
11 welcome such a study would be, such a report would be.
12 But as far as I know, she hasn't published that
13 information.

14 Q So your testimony is that you're basing your
15 assumption that Dr. Adkins doesn't conduct systematic 02:39:28
16 follow-up on her failure to publish a study showing her
17 systematic follow-up?

18 A I'm sorry, you'll have to repeat that. Too
19 many similar phrases.

20 MS. HARTNETT: Can the -- well, I'll try. 02:39:42
21 BY MS. HARTNETT:

22 Q Is the basis for your assumption that
23 Dr. Adkins doesn't engage in systematic follow-up of
24 her patients her failure to publish research indicating
25 her systematic follow-up? 02:39:52

1 A No. I am sure Dr. Adkins follows her
2 patients, but she's a pediatrician, basically, and
3 usually, and I can't be certain about this, that at 18,
4 pediatrics people turn the kids over to adult
5 endocrinologists. 02:40:23

6 And so I think just in the nature of being a
7 pediatric endocrinologist, although she may see some
8 kids into their 20s, I would imagine that the usual
9 trend in pediatrics is to hand kids off, when they're
10 18, to other practitioners; and, therefore, she 02:40:37
11 probably has limited systematic follow-up after 18.

12 And if you extend that by years, like five
13 years and ten years and so forth, I would imagine that
14 she may have a case or two that she follows or knows
15 about, but it would not be anything like systematic. 02:40:55

16 So the answer to your question is the basis --
17 did she not publish, and that's the basis. I'm giving
18 you an additional basis.

19 Q Thank you. You mentioned one patient you had
20 followed up over the course of 30 years, and I think 02:41:10
21 said something like maybe 20 or -- how many patients,
22 overall, do you feel like -- do -- do you believe that
23 you followed up with over a period of decades in your
24 practice?

25 A Very -- very few. Because I exist in America, 02:41:26

1 and in America, we have no means of guaran- -- of -- of
2 insisting on follow-up.

3 And on -- in -- another reason why is that
4 when people transition, they -- they want to get rid of
5 their professionals who dealt with them, and they don't 02:41:47
6 naturally come back.

7 In fact, all attempts at follow-up, not just
8 in my clinic, but elsewhere, we -- we reach -- we reach
9 very few people.

10 For example, in a 2002 study of everyone who 02:42:02
11 had sex reassignment surgery by one surgeon, only
12 30 percent of the people who ever had surgery by this
13 one surgeon actually were available for follow-up.

14 And all follow-up studies -- very few
15 follow-up studies can have a hundred percent of the 02:42:22
16 data of all the patients.

17 Follow-up is a problem. It's a much better
18 problem -- it's solved much better in Scandinavia than
19 it is in the United States. The United States have 50
20 states. They have different rules. Nobody -- I don't 02:42:39
21 think we -- we don't publish follow-up studies in the
22 United States very often.

23 Q What do you do to try to follow up with your
24 patients?

25 MR. TRYON: I think we have a connection 02:43:08

1 problem.

2 MS. HARTNETT: Is that me? It could be me.

3 THE VIDEOGRAPHER: We're just going to pause
4 and see if he -- there he is. He's back.

5 MR. TRYON: There -- he came back. 02:43:15

6 BY MS. HARTNETT:

7 Q Sorry, I think you froze.

8 Did you hear my question?

9 MR. BROOKS: No, I think we don't -- we did
10 not hear a pending question in this room. 02:43:32

11 Can you hear us now?

12 MS. HARTNETT: Okay. Sorry. The video froze
13 from your end.

14 MR. BROOKS: We -- we see --

15 BY MS. HARTNETT: 02:43:40

16 Q My question was, what do you do to follow up
17 with your patients?

18 A I ask them to follow up with me after their
19 surgery, for example, or after their consultation with
20 another person, another professional, and they actually 02:43:54
21 rarely do.

22 Q Do you try to find them if they don't come
23 back to you --

24 A Yes.

25 Q -- afterwards? 02:44:07

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1 A Yes.

2 Q How?

3 A I write them notes. I write them a letter.

4 Sometimes I write them a cute little postcard reminding

5 them of who I am. But they know what I mean. 02:44:15

6 Q If you have such limited follow-up with your

7 own patients, how do you know your method has -- what

8 the effect of your method is on people 30 years later?

9 A I don't know. And I -- I am like other people

10 in this field. I don't know the 30-year implication of 02:44:47

11 what we're doing. I don't know the 20-year implication

12 of what we're doing. I'm just raising the question,

13 shouldn't we be concerned about a life course

14 perspective.

15 I don't know and the people who are advocates 02:45:05

16 don't know, you see. I don't know how they can be so

17 sure that they're going to create a happy life.

18 Q So for all you know, your method could

19 actually be harming your patients more than the other

20 methods; is that fair? 02:45:24

21 A You mean in the long run I may be harming them

22 by talking with them, say, for six months about their

23 decision, what -- what they should go -- what -- what

24 they want to do?

25 I can't imagine that -- that my 02:45:48

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1 psychotherapeutic -- my relationship with them that is
2 helping them to consider their thoughts, their feelings
3 and their futures is -- is harming them and in 30 years
4 they're going to have some terrible result of my
5 intervention, you see. 02:46:07

6 What you're trying to contrast is talking to a
7 person, say, for six months, every -- twice, three
8 times a month for six months with socializing them in a
9 new gender or supporting, giving them hormones and --
10 and saying yes to genital surgery or mastectomy or 02:46:24
11 sterilizing procedures, you see.

12 You're comparing Dr. Levine or
13 psychotherapeutic talking, conversation, extended
14 evaluation, with major biologically sterilizing,
15 sexually dysfunction in causing interventions. 02:46:44

16 I really think -- we're not talking about
17 apples and oranges here. I think we're talking about
18 apples and zebras.

19 Q Your report discusses four competing models of
20 therapy; correct? 02:47:13

21 A Correct.

22 Q So you have the apple, the zebra and two other
23 things in that; correct?

24 MR. BROOKS: Objection.

25 THE WITNESS: No. 02:47:20

1 BY MS. HARTNETT:

2 Q The four competing models are watchful
3 waiting, sub 1; sub 2, psychotherapy; and the
4 affirmation model.

5 That's what you've set forth; correct? 02:47:30

6 A That's right.

7 Q And I'm asking you whether, for all you know,
8 the psychotherapy model may be creating more harm for
9 people than the affirmation theory model. You just
10 don't know? 02:47:46

11 A I think I've already testified that it's hard
12 for me to even conceptualize that I'm causing harm.
13 Sometimes I'm causing frustration because "I want
14 hormones now" and you're 14, and I'm sorry, we have --
15 I want to talk about this. 02:48:14

16 But I don't really think that's harm in the
17 way that when I look at the cross-sectional data on
18 adults who have transitioned and -- and the
19 comorbidities that they have, I consider those to be
20 manifestations of harm, you see. 02:48:32

21 I don't really think that talking briefly
22 and -- and honestly and examining things is -- is a
23 source of harm.

24 It is --

25 Q But your -- your practice isn't to talk 02:48:46

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1 briefly to someone. You're talking -- right?

2 The -- the -- the model that you're setting
3 forth is to talk with them at length and get to know
4 them; correct?

5 A Yes, this used to be the model -- before 2011, 02:48:55
6 this was the endorsed model by the World -- by WPATH,
7 you see. I'm not talking -- I'm not inventing a new
8 model here. This was the model we had in the '60s, the
9 '70s, the '80s and the '90s and in the 2010s and --

10 Q And it's your view that the psychotherapy -- 02:49:14

11 A The view model changed.

12 Q It's your view that the psychotherapy model
13 cannot, by its nature, harm anyone?

14 A I know some people think that it harms people.
15 I don't believe that, actually. 02:49:28

16 Q Well, let me give you an example.

17 Say you're meeting with a patient and they
18 want to talk you about their need or their perceived
19 need for cross-sex hormones and you don't agree or
20 choose not to support them with a letter. 02:49:45

21 Do you -- is that a fair -- just assume that,
22 okay?

23 And that person then goes on to stop seeing
24 you, has been taken off course from getting the
25 cross-sex hormones, ends up becoming distraught at 02:49:55

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1 their condition and commits suicide.

2 Is that a situation where the psychotherapy
3 model might be responsible for causing harm?

4 MR. BROOKS: Objection; calls for speculation.

5 MR. TRYON: Objection. 02:50:08

6 THE WITNESS: If that -- such a patient goes
7 to me -- comes to me and after -- in the first session
8 wants a letter and I refuse to provide it, I will help
9 that person -- if the person doesn't know, I will refer
10 them to clinics -- to other resources. 02:50:26

11 The idea that my refusal would cause them to
12 suicide is enormous and deep that leaves out so many
13 intervening factors as to make me say I can't possibly
14 agree with what you said.

15 BY MS. HARTNETT: 02:50:43

16 Q But it's possible that your patients, for
17 example, have higher rates of suicide than other
18 patients that have gone through a different model;
19 correct? You just don't know?

20 MR. TRYON: Objection. 02:50:52

21 THE WITNESS: It's equally possible that the
22 patients have a lower rate of suicide that have gone
23 through Dr. Levine's care.

24 BY MS. HARTNETT:

25 Q But it's also possible that they have had a 02:51:04

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1 higher rate of suicide going through Dr. Levine's care;
2 correct?

3 MR. BROOKS: Objection --

4 MR. TRYON: Objection.

5 MR. BROOKS: -- calls for speculation. 02:51:13

6 BY MS. HARTNETT:

7 Q You said it's possible that they have a lower
8 rate. It seems that the flip side of that is it's
9 possible that they had a higher rate; is that correct?

10 A You're -- 02:51:23

11 MR. BROOKS: Same -- same objection.

12 THE WITNESS: You're asking me to speculate
13 about something you know I don't have the answer to, so
14 why should I give you an answer that I don't have? Why
15 are you asking -- 02:51:32

16 BY MS. HARTNETT:

17 Q You testified that it's possible that --

18 MS. HARTNETT: I'm going to ask for an answer
19 to my question without coaching, please.

20 BY MS. HARTNETT: 02:51:37

21 Q My -- I asked if it's possible that the
22 patients of Dr. Levine have a higher rate of suicide
23 than patients going through another method, and then
24 you responded it's possible that they have a lower --
25 lower rate. That's an answer. 02:51:49

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1 I'm asking you, is it possible that they also
2 have a higher rate?

3 MR. BROOKS: And I have objected to the
4 question as calling for speculation.

5 BY MS. HARTNETT: 02:52:01

6 Q Please answer.

7 A In order to -- in order to have an answer to a
8 rate question, one has to have a denominator and
9 numerator. I have neither a denominator or numerator;
10 and, therefore, I can't really ask -- in any expert 02:52:23
11 way, I cannot answer a question about the rate.

12 You're asking me theoretical possibilities,
13 and there probably are at least three theoretical
14 possibilities, and I could probably think of more,
15 but -- 02:52:40

16 Q What are the three?

17 A There would be no difference in the rates,
18 right? The rates could not be ascertained because the
19 denominator -- the numerator and the denominator
20 couldn't be determined. And then the fifth one would 02:52:52
21 be because the numerator can't be determined.

22 So if you ask me a question about rate, it's a
23 mathematical question. It's a scientific question.
24 But you're not asking it in a scientific way at all.
25 And I can't answer it. 02:53:07

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1 To the extent that I have any expertise, it's
2 on the science. It's not on the speculation side of
3 things.

4 Q Your expert opinion is that the affirmative
5 model is more harmful than the psychotherapy model; 02:53:18
6 correct?

7 A My -- my expert opinion is that the
8 affirmative model does not have the scientific
9 justification to declaim -- to -- to declare it to be
10 the best practice. That's my expert opinion that -- 02:53:35

11 Q Does the psychotherapy model have any more
12 justification than the affirmative model?

13 A Only the tradition that if any other
14 psychiatric problem presented in a 14- or 15-year-old,
15 no one, no one would object to an extended evaluation, 02:53:53
16 a psychotherapeutic exploration and the use of a
17 medication to a drug -- to address some comorbidity.

18 It's just that when a -- when the child
19 declares themselves trans, we want to create a whole
20 different approach to this situation. That's my point. 02:54:12

21 Q And just to make sure that we close the loop
22 on the other point, because I'm not quite sure what the
23 answer was there, is it your testimony that it's
24 possible that your -- that Dr. Levine's patients could
25 have lower rates of suicide than other methods? 02:54:29

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1 MR. BROOKS: Objection; calls for speculation.

2 THE WITNESS: I'm afraid -- although you don't
3 understand my answer to the question, I feel like I've
4 answered the question repeatedly already.

5 BY MS. HARTNETT: 02:54:46

6 Q Well, you've said that it could be -- I
7 thought you -- I thought I understood you to say you
8 could have lower rates, you could have a missing
9 numerator or denominator or equivalent, but I didn't
10 hear whether or not you think another possibility is in 02:54:54
11 fact that the rates of suicide could be higher from
12 your patients.

13 A Well, perhaps you missed the implication of
14 what I said, that it could be higher, it could be
15 lower, it could be the same, it could be indeterminant 02:55:06
16 because of the denominator issues, and it could be
17 indeterminant because of the numerator issues.

18 Q I appreciate that. Thank you.

19 We've talked about Dr. Adkins a bit here. I
20 just wanted to ask you -- this is flashing back to -- I 02:55:22
21 think we're in paragraph 13.

22 You then go on, in paragraph 16, to talk about
23 Dr. Safer. Let me know when you're there.

24 A Got it.

25 Q Other than reviewing Dr. Safer's expert 02:55:43

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1 report, do you have any other familiarity with
2 Dr. Safer's practices?

3 A I believe he's the head of a New York gender
4 team, clinic.

5 Q Have you ever met him before? 02:55:58

6 A Not that I am aware of.

7 Q Have you ever been to his clinic?

8 A No.

9 Q Have you ever spoken to any of his patients?

10 A Not that I'm aware of. 02:56:11

11 Q How about Dr. Adkins, have you been to her
12 clinic?

13 A No.

14 Q Have you spoken to any of her patients?

15 A Not that I'm aware of. 02:56:23

16 Q So do you know whether or not Dr. Safer's
17 approach is focused on creating a happy, healthy --
18 sorry -- happy, highly functional, mentally healthy
19 person for the next 50 to 70 years?

20 A Ms. Hartnett, I think everyone in this field 02:56:42
21 is hoping that what they're doing is creating that
22 outcome. I would presume that Dr. Safer believes that
23 and Dr. Adkins believes that. I just go back to the
24 fact that we don't know the answer in what they're
25 doing and what they're doing is a rather dramatic 02:57:04

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1 interventions in a person's biology, their physiology,
2 their anatomy and their social roles, and it seems to
3 me that if we're making such a very, very
4 life-changing -- or cooperating with such a life
5 change, a profound life change, that's going to effect 02:57:21
6 every aspect of their lives, or most aspect of their
7 lives, we ought to at least acknowledge that we don't
8 have the follow-up data to match our belief systems.

9 And as I wrote about in the most recent
10 publication, I do think that ethically we have a 02:57:40
11 responsibility to inform people of what science knows
12 and what we as professionals believe, but it's not
13 supported by science.

14 So in answer -- to summarize my answer, I
15 believe that your experts believe that they are 02:57:58
16 creating a happy, healthy, functional life, even in the
17 face of the fact that they -- cross-sectional studies
18 of adults who are transgender and those who have had
19 complete medical surgeries have significant problems.

20 And so what I have been saying, in summary, is 02:58:18
21 that we -- we should separate our beliefs from what
22 science knows.

23 Q You said "cross-sectional studies." You're
24 just saying that those are lacking to -- to -- to -- to
25 substantiate their approach. Is that what you're 02:58:37

1 saying?

2 A Please repeat that. You sort of -- I couldn't
3 understand.

4 Q Sorry. You had -- yeah, fair -- fair enough.

5 I think you said something about 02:58:44
6 cross-sectional studies being lacking to support their
7 approach. Is that what you were saying?

8 A Yes. Not only cross-sectional studies failed
9 to support the idea that everyone is living happily
10 ever after or the majority are living happily ever 02:59:04
11 after, the -- the Swedish study that was published in
12 2011 that had outcome data on everyone who had sex
13 reassignment surgery over a 30-year period. You may
14 know that as the D-H-E-N-J-A (sic) study, et al. They
15 demonstrated -- the -- the recommendation of that study 02:59:26
16 is that everyone after sex reassignment surgery should
17 have lifelong psychiatric care because the suicide rate
18 was 19 times higher after this than the general
19 population. The death rates were higher of cancer and
20 of heart disease, the criminal rates were higher, and 02:59:45
21 the admission rates to psychiatric hospitals were
22 higher, after, then general population.

23 So that group in Sweden, in 2011, said, wow,
24 these people are not necessarily doing so well as a
25 group; that is, everyone that was -- everyone who had 03:00:01

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1 sex reassignment surgery was in that. So
2 we wouldn't -- we wouldn't call that a cross-sectional
3 study. We would have a life perspective study, you
4 see. You are aware --

5 Q Was that -- was that comparing it to the 03:00:14
6 general population, though? Not transgender people
7 that had gone untreated, right?

8 A That study did not include people who were not
9 treated with surgery, that's right.

10 Q Right. So to figure out if surgery makes a 03:00:26
11 difference, wouldn't you study a population that had
12 had surgery versus the population that had not had
13 surgery, all of transgender people?

14 A Yes, I often wondered why the authors of that
15 study did not study those people that they had records 03:00:39
16 on who didn't have surgery. It's one of the missing
17 issues about that. It doesn't take away from the fact
18 that relative to non-transgender people of either sex,
19 these people don't do nearly as well in life. But it
20 doesn't answer the question that you're raising, and 03:00:59
21 that's been amazing -- that's an amazing absence. One
22 wonders why that is absent. I don't know why.

23 Q So just to be clear, the -- the thing that's
24 absent is testing whether or not it's actually the
25 medical interventions with the transgender people that 03:01:16

1 are accounting for the difference in suicide from
2 the -- is that what you were saying?

3 MR. BROOKS: Objection; vague.

4 THE WITNESS: I'm saying that it would have
5 been nice to have four control groups. And they only 03:01:35
6 had three control groups. And I don't --

7 BY MS. HARTNETT:

8 Q Right.

9 A I don't understand why there wasn't the fourth
10 control group that you are raising because it does -- 03:01:43
11 you know, I already testified that nothing is certain,
12 but this would have increased our conviction about
13 whether or not people are dying of cancer and heart
14 disease and HIV and suicide and so forth at a higher
15 rate compared to those who are transgender but who 03:02:08
16 weren't getting the surgery.

17 So I don't know the answer.

18 Q Could I go to -- paragraph 18 has several
19 subparagraphs. I just have a couple of questions on
20 this. The first is on paragraph 18A. 03:02:28

21 I just had a -- it was a minor reference, but
22 I'm just curious about your own use of terminology.
23 You had, here in the second sentence of 18A (as read):

24 "While hormonal and surgical
25 procedures may enable some individuals 03:02:45

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1 to 'pass' as the opposite gender
2 during some or all of their lives..."

3 And the sentence continues.

4 In the declaration you had -- that had been
5 filed, your declaration that was filed at the PI stage, 03:02:55
6 the words "female identifying male" were used instead
7 of "some individuals."

8 Is -- is there a reason why that would have
9 been changed?

10 A In the original -- what was in the original 03:03:15
11 draft that you looked at?

12 Q It said "a female identifying male" as opposed
13 to "some individuals."

14 MR. BROOKS: I'll object to the question as
15 characterizing that as original. 03:03:24

16 BY MS. HARTNETT:

17 Q Well, it was the declaration -- I compared the
18 declaration that was apparently submitted without your
19 knowledge on your -- in -- in the PI stage of this case
20 with the report, thinking that you had done both of 03:03:36
21 them, and I'm -- what I'm just observing was that the
22 words "female identifying male" had been used in this
23 paragraph and then now has been replaced by "some
24 individuals," and I'm just curious as to why that
25 change was made, if you know. 03:03:47

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1 A I don't know. I don't remember that phrase.

2 That seems like -- that seems like a rather awkward
3 phrase, you know, that you quoted.

4 Q Yeah, why -- is that a phrase you use --

5 "female identifying male," is that a phrase that you 03:04:00
6 use?

7 A I -- I may have at one time or another used
8 that phrase.

9 Obviously, for everyone concerned, the
10 language -- the vocabulary -- the -- the -- the 03:04:12
11 socially acceptable vocabulary in this field changes so
12 often.

13 So, you know, as I told you, I spent probably
14 25 hours developing this, and there are numerous
15 changes here and there which I could not possibly 03:04:33
16 recall.

17 And I can't answer your question. I really
18 don't know the answer.

19 Q Okay. Well, I'll ask one more in that vein,
20 and then we'll move on. 03:04:42

21 For paragraph 18L, which is at the top of
22 page 8 -- and this a paragraph where you're
23 describing -- you say that (as read):

24 "Hormonal interventions to treat
25 gender dysphoria are experimental in 03:05:01

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1 nature and have not been shown to be
2 safe, but rather put an individual at
3 risk of a wide range of long-term and
4 even life-long harms..."

5 And then you go on to list all that. 03:05:10

6 A Yes.

7 Q The prior version of this -- in the same place
8 had -- had language that said -- I'm going to just read
9 it to you. (As read):

10 "Putting a child or adolescent on a 03:05:21
11 pathway towards life as a transgender
12 person."

13 And that has been removed. I'm just curious
14 as to why that was removed.

15 MR. BROOKS: Late objection. 03:05:28

16 THE WITNESS: I actually -- I can't give you a
17 specific answer to the question. I have no memory
18 of -- of -- of making that editorial change.

19 I -- I -- I am sensitive to and actually have
20 a preference to not using the same phrase endlessly in 03:06:01
21 any document. And one of my concerns about previous
22 documents has been the redundancy of phrases, and so
23 I -- I try not to repeat certain powerful phrases.

24 I -- I think they actually have more impact on the
25 reader if they read them once or twice and not 15 03:06:26

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1 times. So that may have been an example of that.

2 As a writer, I'm very sensitive to redundancy,
3 and I prefer to have things done short -- in shorter
4 versions than in longer versions, but that is not
5 always in keeping with legal requirements. 03:06:46

6 Q Turning to paragraph 19, this is -- I'm not
7 going to -- there's a couple of questions I had
8 about -- or, sorry, not -- 20. You're talking about
9 biological sex.

10 Do you see that? 03:07:01

11 A Yes.

12 MR. BROOKS: Sorry, you want 19 or 20?

13 MS. HARTNETT: I'll move to 20.

14 BY MS. HARTNETT:

15 Q You say that (as read): 03:07:08

16 "Sex is not 'assigned at birth' by
17 humans visualizing the genitals of a
18 newborn; it is not imprecise.

19 Do you see that?

20 A Yes. 03:07:17

21 Q Do you have any experience with the process of
22 assigning sex to newborns at birth?

23 MR. BROOKS: Objection.

24 THE WITNESS: You know, I -- probably for a
25 week in my medical school pediatrics rotation I was 03:07:32

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1 part of the newborn nursery and delivery -- and in
2 obstetrics. The newborn delivery room phenomenon of
3 saying, Mother, your -- you have a daughter. Or,
4 Mother, you have a son. So I guess that's part of my
5 experience. I'm a parent, so I've had that experience. 03:07:52
6 What I -- period. I think that's an answer.

7 BY MS. HARTNETT:

8 Q Thank you. You also say in this paragraph,
9 among other things, that sex is determined at
10 conception; correct? 03:08:06

11 A Yes, when -- yes, I do -- that's when sex is
12 determined, yes.

13 Q You say that at the end of the first
14 sentence of -- sorry -- the second sentence of
15 paragraph 20. And the source that you cite in this 03:08:22
16 paragraph for everything in this paragraph is a
17 document that says "NIH 2022."

18 Do you see that?

19 That's at the top of page 9.

20 A Yes. 03:08:34

21 Q What is NIH 2022?

22 A I think the first author's name is Aditi
23 B-H-R-A-R- -- Bhar- -- Bhargara or something like that,
24 but it has probably 15 authors, the paper.

25 Q So that's a paper that you were citing? 03:08:55

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1 A Yes.

2 Q Okay. Let me move down to section D. So that
3 starts on page 14 of your report.

4 MR. BROOKS: We have it.

5 BY MS. HARTNETT: 03:09:26

6 Q And you -- this is your section about "Three
7 competing conceptual models of gender dysphoria and
8 transgender identity."

9 Do you see that?

10 A Yes. 03:09:35

11 Q Is this your construct, these three models?

12 A Yes.

13 Q Paragraph 37, you describe the developmental
14 paradigm, I guess; is that fair?

15 A Yes. 03:09:50

16 Q I was comparing the declaration submitted at
17 the earlier stage of the case with the report here, and
18 I noticed that some language was deleted, and I will
19 double-check to represent to you that it is not still
20 here. 03:10:09

21 But the language that was deleted from
22 paragraph 37 is as follows (as read):

23 The developmental paradigm does not
24 preclude a biological temperamental
25 contribution to some patients'

03:10:22

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1 life (sic); it merely objects to
2 assuming these problems are biological
3 in origin. All sexual behaviors and
4 experiences involve the brain and the
5 body." 03:10:31

6 Is there some reason that you removed this
7 language from this report?

8 A Well, I think I said it in a different way. I
9 said (as read):

10 "The developmental paradigm is mindful 03:10:42
11 of temperamental, parental bonding,
12 psychological, sexual, and physical
13 trauma influence (sic), and the fact
14 that young children work out their
15 psychological issues through fantasy 03:10:53
16 and play and adolescents work out
17 their issues by adapting various
18 interests and identity labels."

19 This is -- this is the material that I
20 prepared as the expert witness report for this 03:11:07
21 particular case.

22 Over time, you see, I have a different -- I --
23 I say things more efficiently, I believe.

24 I could elaborate that, but I don't think it's
25 relevant. 03:11:27

1 Q No. Thank you. I appreciate it.

2 But you agree, sitting here today, that all
3 sexual behaviors and experiences involve the brain and
4 the body?

5 A I agree that all behaviors involve -- well, 03:11:38
6 the brain and the body is really one thing, you know.
7 They're just part of the biology of a -- of the
8 human -- of human beings, and that -- those biology --
9 multiple biologic factors interact with other
10 psychosocial factors throughout life to shape our 03:12:03
11 feelings and our behaviors and so forth.

12 Q In paragraph 38, you refer to a Littman 2018
13 study.

14 Do you see that?

15 A Paragraph 38, yeah. 03:12:17
16 Yeah.

17 Q Are you aware that that article was -- had to
18 be withdrawn and corrected and republished?

19 MR. BROOKS: Objection.

20 THE WITNESS: I am aware that there was a lot 03:12:32
21 of political brouhaha about that and that various trans
22 advocates accused that author of bad things or whatever
23 but that the restatement of the study really did not --
24 did not amount to a great change.

25 But -- but, in fact, there was a brouhaha by 03:13:01

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1 the publication objecting to her methods so to speak,
2 but really were -- they were objecting to her
3 conclusions.

4 BY MS. HARTNETT:

5 Q Was her method an anonymous survey of parents? 03:13:16

6 A Her -- it was a survey of parents, right.

7 Q Do you know if they were anonymous or not?

8 A At this moment, I don't know.

9 Q You go on in section E here, starting on
10 page 16, to talk about four competing models of care. 03:13:32

11 MR. BROOKS: Sorry.

12 BY MS. HARTNETT:

13 Q I also was wondering --

14 MS. HARTNETT: Oh, sorry.

15 MR. BROOKS: I hit the wrong thing, and the 03:13:38
16 document disappeared off the screen. Let me -- I'm not
17 sure what's going on here.

18 Okay. Sorry, I -- it accidentally closed as I
19 tried to get rid of some pop-up on the screen, and we
20 will get us back. 03:14:04

21 And, I'm sorry, what paragraph were you at?

22 MS. HARTNETT: It's section header E, page 16.

23 MR. BROOKS: Page 16.

24 BY MS. HARTNETT:

25 Q I'm just asking whether the four competing 03:14:25

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1 models of care is your schema.

2 A I think it borrows from other things in the
3 literature. I wouldn't want to claim, you know,
4 authorship for that per se. It's really hard for me to
5 know where all my ideas come from because I read so 03:14:54
6 much and go to meetings and so forth, and I hear
7 things, and it influences me.

8 I -- I -- it's my summary of -- when we think
9 about what are the options that we can offer to people,
10 this is all I think of. Maybe tomorrow -- 03:15:11

11 Q Okay.

12 A -- I'll think of a fifth option.

13 Q Can you go down to paragraph 53?

14 And this is after you walk through the
15 watchful waiting model, A and B, a psychotherapy model 03:15:25
16 and then the affirmation model and then coming to
17 paragraph 53.

18 MR. BROOKS: Let me just find the heading
19 above it.

20 So we're under the affirmation therapy model 03:15:38
21 number 4, if I'm scanning the --

22 MS. HARTNETT: Yeah.

23 MR. BROOKS: Okay.

24 MS. HARTNETT: That's correct.

25 And then paragraph 53. 03:15:46

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1 MR. BROOKS: Okay.

2 BY MS. HARTNETT:

3 Q Out of these four models, you do not know what
4 proportion of practitioners are using which model; is
5 that correct? 03:15:57

6 A Yes.

7 Q Okay. Oh, sorry, I had one question about 49,
8 which was within the psychotherapy model area, if you
9 could flip up to there.

10 MR. BROOKS: Yes, let me just find the heading 03:16:11
11 again so we understand how much material --the
12 psychotherapy model begins at the top of page 18, and
13 you now want to direct us to paragraph 49? Was that
14 the paragraph you mentioned?

15 MS. HARTNETT: Correct. 03:16:29

16 MR. BROOKS: All right.

17 BY MS. HARTNETT:

18 Q And is the psychotherapy model the model you
19 follow, Dr. Levine?

20 A It's the model that I approach new patients 03:16:43
21 with, and depending on the situation of the patient in
22 the family's life, I then go from there. So individual
23 patients, I may counsel the support of the -- I may
24 counsel parents to support the transgender
25 identifications of their child. 03:17:09

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1 But it begins with trying to figure out what's
2 going on here and going on here with the child and the
3 child's history and the parents and their history and
4 the interactions between the -- the parents and the
5 child. 03:17:25

6 So it's not my model for all therapy. As I've
7 said, I think earlier, that I have supported trans care
8 for individuals, affirmative care for individuals. But
9 if you ask me how I begin, I don't not -- I do not
10 begin with the affirmative model. I begin with let's 03:17:44
11 investigate this situation thoroughly so we can
12 eventually make a prudent decision.

13 Q You say in paragraph 49 (as read):
14 "To my knowledge, there is no evidence
15 beyond anecdotal reports that 03:18:01
16 psychotherapy can enable a return to
17 male identification for genetically
18 male boys, adolescents, and men, or
19 return to female identification for
20 genetically female girls, adolescents, 03:18:13
21 and women."

22 Do you see that?

23 A I do.

24 Q And you stand by that statement?

25 A Yes. 03:18:24

1 Q Paragraph 50, this is at the beginning of the
2 affirmative therapy model, on the next page. I think
3 we've already covered this, so we don't need to belabor
4 it, but here, you -- among other things, you say that,
5 under the affirmation therapy model, practitioners -- 03:18:44
6 and I'm going to read from the first sentence. And I'm
7 not reading the whole sentence, but you can obviously
8 read whatever you want. I'm reading from the middle of
9 it. (As read):

10 "...promote and recommend that any 03:18:58
11 expression of transgender identity
12 should be immediately accepted as
13 decisive..."

14 I'm just going to stick on that part, the
15 "immediately accepted as decisive." 03:19:08

16 What is your basis for believing that the
17 affirmation model proceeds with an immediate acceptance
18 as decisive?

19 A Because --

20 MR. TRYON: Objection. 03:19:19

21 Go ahead.

22 MR. BROOKS: Mr. Tryon is objecting.

23 You have to give him time.

24 THE WITNESS: In a previous -- in a -- in a
25 previous portion of this informed consent, I said that 03:19:29

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1 it is my impression that many people in the affirmative
2 model have a number of beliefs that I don't think are
3 scientifically accepted or acceptable or correct and
4 including the fact that this is biologically dictated,
5 that anytime a person, any stage in life, declares a 03:19:52
6 transgender identity, it's because prenatally that was
7 determined and it merely unfolded at a different rate
8 at different times.

9 So the -- the justification for immediate
10 affirmation is based upon this idea, one, that it's 03:20:13
11 biologically dictated; and, two, that it's
12 unchangeable.

13 BY MS. HARTNETT:

14 Q Yeah, I'm sorry, I think -- just given that
15 we're -- have only so much time and I -- I think my 03:20:25
16 question, though, was what was your basis for
17 understanding that the practitioners engage in this
18 practice.

19 MR. BROOKS: Objection; vague as to "this
20 practice. 03:20:36

21 BY MS. HARTNETT:

22 Q Well, the practice of immediate acceptance as
23 decisive.

24 A I think I've already testified how many
25 parents have told me these things and how many patients 03:20:43

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1 have told me these things and -- and -- well, I won't
2 repeat what I began to tell you about.

3 Q No. Thank you. That -- that just helps me
4 connect that that -- that basis of evidence is the same
5 that's at issue here. 03:20:59

6 Paragraph 56, I had a question there.

7 MR. BROOKS: And, Counsel, we should take an
8 hourly break soon.

9 MS. HARTNETT: Now is fine.

10 MR. BROOKS: All right. Now is it -- now it 03:21:14
11 is.

12 THE VIDEOGRAPHER: We are off the --

13 MS. HARTNETT: Come back at --

14 THE VIDEOGRAPHER: Off the record at 3:21 p.m.

15 (Recess.) 03:35:28

16 THE VIDEOGRAPHER: We are on the record at
17 3:36 p.m.

18 MR. BROOKS: And -- and --

19 MS. HARTNETT: Thank you.

20 MR. BROOKS: -- Josh, if you would turn off 03:35:34
21 your camera, you will -- will be able to see the
22 questioner better.

23 There we go. Thank you.

24 MS. HARTNETT: Okay. Great.

25 ///

1 BY MS. HARTNETT:

2 Q Before the break, we were talking, at least a
3 bit, about the four models that you had in the
4 psychotherapy model, and I was asking you if you follow
5 that, and we were having a discussion. And I want to 03:35:54
6 make sure I don't misconstrue your approach.

7 Is it fair to say that you kind of follow the
8 psychotherapy model, but also not to the exclusion of
9 providing medical care or recommending medical care, if
10 it's appropriate, after some course of psychotherapy? 03:36:07

11 A Yes, I -- to summarize, the initial approach
12 to a patient, I believe my model, what I endorse, is an
13 extended evaluation, an opportunity to talk over time
14 in what I call psychotherapy. Other people may call it
15 extended evaluation. And then depending on what I 03:36:34
16 understand about the patient and his or her life and
17 their aspirations and their capacities to understand
18 the present and the future and the past, then I may in
19 fact say, you know, Fine. You know, do what you -- do
20 what you -- use your best judgment. And I will write a 03:36:55
21 letter for you, you know, telling your -- the surgeon
22 or telling the endocrinologist about you.

23 And I do that.

24 Q And was that general approach extended to
25 minors as well? 03:37:17

1 A Well, if -- if minors are children, I actually
2 have never recommended socialization of a child in
3 that -- that is, in a new gender. I have seen -- I
4 have never recommended that.

5 When it comes to teenagers, the closer they 03:37:36
6 get to 18, the more I'm willing to talk to them about
7 the possibility of hormones and being supportive of it
8 after a certain period of time.

9 When it comes to older people, it's -- it's
10 not as broad a question. 03:37:57

11 Q And how long is your -- when you discuss an
12 extended evaluation, how -- how long is that?

13 A It doesn't have a definable length.

14 Q Is there -- and I'm just trying to really
15 understand. Is it a matter of hours, days or longer? 03:38:13

16 A It's certainly -- a -- a psychotherapeutic
17 hour is typically one; right? But when people come to
18 Cleveland for an evaluation, I often spend two days.
19 And so I may spend, you know, four hours over two days
20 or maybe even more with a patient and then separately 03:38:37
21 with their parents and sometimes together with their
22 parents.

23 But when I'm talking about an extended
24 evaluation, I mean that in two terms. One is for
25 people who want to come for an intense evaluation that 03:38:53

1 at the end of two days will give some -- give some
2 feedback to them and -- but the usual sense for people
3 who live in Cleveland, where I reside, that is over
4 weeks and months of talking over time, considering
5 various -- the things I've already articulated. 03:39:14

6 Q Have there been situations where after the
7 sort of intense extended evaluation, the two days
8 and -- four hours over two days period, where you've
9 supported or recommended any medical treatment after
10 that period? 03:39:33

11 A Well, about -- about a year ago, a -- a --
12 a -- a college student who wasn't doing very well, who
13 got actually hormones on a one-hour visit, to the
14 student health service, the -- we recommended that the
15 patient could decide whether to continue hormones or 03:39:53
16 not. The parents did not want the person to continue
17 hormones, and the patient continued hormones. And we
18 just made a recommendation. We thought there was an
19 advantage to stopping and reconsidering life, but it
20 was the patient's choice, you see. It wasn't the 03:40:12
21 parents' choice. It wasn't my choice, you see. But
22 it's the respect for the patient's autonomy.

23 Q Did you write a letter there or some sort of
24 authorization for him to get the hormones?

25 A No. He already had the hormones. As I said, 03:40:29

1 he got the hormones after one hour with a person who
2 knew nothing about his background, really, that -- what
3 I would say, relatively nothing.

4 Q Where was that treatment?

5 A That was at the University of Rochester. 03:40:40

6 Q Okay. So -- and then my question is just for
7 kind of -- I guess, what's the shortest period of
8 extended evaluation that you've performed after which
9 you've written a letter for someone to get transgender
10 medical care? 03:41:00

11 A I'm going to elaborate your question into me
12 or my staff because in some --

13 Q Thank you.

14 A It's a whole -- it's a committee of work, a
15 group of people. 03:41:13

16 I would say four hours.

17 Q Thank you. You had mentioned your -- the
18 recently published article about the -- the
19 reconsidering informed consent piece; correct?

20 A Yes. 03:41:32

21 Q And in there, you note that -- kind of --
22 you're talking about the affirmation -- what you
23 characterize as the affirmation approach; right?

24 A Correct. There's a section on that, yeah.

25 Q And then you note that the "research about 03:41:46

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1 alternative approaches, such as psychotherapy or
2 watchful waiting, shares the scientific limitations of
3 the research of more invasive interventions; there are
4 no control groups, nor is there systematic follow-up at
5 predetermined intervals with predetermined means of 03:42:03
6 measurement."

7 Does that --

8 A Yes.

9 Q Is that something you have in the article?

10 A I think I made the same point in -- in this 03:42:10
11 document that I gave to you.

12 Q Right. I was just trying to connect the two.

13 So that's basically the same point you've been
14 making, that -- the kind of lack of evidence, from your
15 perspective, as to which approach is kind of 03:42:26
16 scientifically based; is that right?

17 A Yes.

18 Q Okay. If we could flip forward, I -- sorry,
19 going backward for a minute and then we'll go forward
20 again, in your declaration, but I had a question about 03:42:36
21 paragraph 18, little L. Sorry, that's not right. It
22 is 18, little -- sorry, one second.

23 I'll try again.

24 Can I direct your attention to paragraph 18H,
25 on page 7? 03:43:03

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1 MR. BROOKS: And let me just first start on
2 the top of 18 so we know what the major proposition
3 here -- a summary of key points. All right.

4 And, I'm sorry, you said H?

5 MS. HARTNETT: Correct. 03:43:18

6 BY MS. HARTNETT:

7 Q So I'm going to direct your attention to
8 paragraph H, on page 7, which you talk about
9 administration of puberty blockers not being a benign,
10 quote, pause of puberty. 03:43:31

11 Do you see that?

12 A I do.

13 Q And this, I noticed, was something newly added
14 to this declarations from the one that you had
15 submitted at the preliminary injunction stage. 03:43:42

16 My question for you is what the basis is for
17 your qualification, in your perspective, to talk about
18 the effects of puberty blockers.

19 MR. BROOKS: Object to the form of the
20 question. 03:43:57

21 THE WITNESS: What is the basis of my
22 objection to the use of puberty blockers?

23 BY MS. HARTNETT:

24 Q Sorry, the basis for your understanding of
25 whether -- how they function on the body and whether 03:44:04

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1 they're a benign pause of puberty or not.

2 A The initial justification for puberty blockers
3 being a benign thing is that it merely was a pause and
4 that if it was fully reversible, puberty would -- would
5 return when puberty blockers were removed, if they were 03:44:32
6 chosen to be removed.

7 I often reacted to that word "pause" because I
8 was aware that I was unaware of the rich biological
9 details that puberty changes every organ in the body.
10 Puberty not only causes growth of bones, but puberty 03:44:53
11 causes growth of the liver, of the lungs, of the heart,
12 of the brain. You name the organ, and the pubertal
13 changes are occurring, and they occur in a sequence.
14 And one of the developmental aspects of development is
15 that there are windows of opportunity for development, 03:45:15
16 and when the window closes, we're not sure whether
17 things can be totally reversed.

18 And I noticed that there was a benign
19 connotation to the word "pause" which did not strike me
20 as true or possibly true or certifiably true. 03:45:35

21 And so I began looking at various statements
22 from various authors about saying this.

23 And in the early years, people talked about
24 complete reversibility and it's only a pause, but I
25 realized, in reading their subsequent sentences, that 03:45:56

1 they didn't consider -- they were talking about bone.
2 They were talking about the onset of puberty. They
3 weren't talking about the subtle changes of -- of, say,
4 for two or three years of interfering with the
5 processes that were naturally happening in your and my 03:46:11
6 children and the children of society.

7 So -- and then I looked closer at it, and I
8 said, what about the impact, the psychological, social,
9 sexual impact of having one's peers have these major
10 changes in every aspect of their body while the person 03:46:31
11 was paused in a puerile state, has anyone considered
12 that when they said it's completely reversible.

13 Nowadays, I think people are not certain it's
14 completely reversible, and they're beginning to
15 articulate the possibility that I just articulated. 03:46:53

16 They're beginning to say we don't know what
17 the psychosocial impact of being puerile while your
18 peers are pubertal.

19 And while your peers are pubertal, you're
20 getting -- you're starting to deal with your sexual 03:47:10
21 feelings and your sexual conflicts, and you're getting
22 to operationalize your -- what the early orientation
23 aspects of early puberty are, you see. And the puerile
24 child is not.

25 And so I thought the word pause was a kind of 03:47:23

1 rhetoric that -- that justified doing something that
2 was much more complicated and had not been articulated
3 well by the people who began using it.

4 I'm not sure that today's people are talking
5 in the same way that they did when -- 20 -- ten years 03:47:41
6 ago.

7 Q When did you come to --

8 A I think they're more sophisticated today.

9 Q When did you come to this understanding or
10 view about the -- your kind of concern with using the 03:47:53
11 term "pause"?

12 A I think it's been evolving in my mind over the
13 last two or three years.

14 Q Do you know whether the pubertal response
15 would be the same -- basically, if the puberty blockers 03:48:06
16 were used and then a child were to go off the puberty
17 blockers, do you know whether it would be the same
18 pubertal response that would have been had without the
19 blockers?

20 A Well, I think endocrinologists have said that 03:48:21
21 it's same, but I don't know if they have even the -- I
22 don't know that -- I don't know that I trust that
23 they're right about that. I don't know that they're
24 wrong. I just don't know that they're right. Because
25 in concepts of development -- for example, if you 03:48:43

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1 don't -- if you don't hear at a certain stage in life,
2 say the first two years of life, and even if we do a
3 cochlear implant, and we put -- we -- you can hear
4 starting at age three or age four or age five, you
5 can't speak as clearly as you and I can speak. 03:49:01

6 So, you see, there's a window of opportunity
7 when the brain is changing and we -- it's -- that --
8 that other -- other aspects of life develop. And I
9 think this is probably true throughout life as a
10 principle. 03:49:18

11 So the idea that, oh, we can give a kid for
12 three years or four years and keep them paused while
13 they decide what they want to do, whether they want to
14 go cross-sex hormones or not, and then if they decide
15 not to go the cross-sex hormone route, that they will 03:49:33
16 just go into puberty and everything be normal, I just
17 think that's a naive idea. But I was proposing that,
18 you see. I can't prove it and either can -- either can
19 the endocrinologist prove it. That's my point.

20 Q Thank you. 03:49:47

21 MS. HARTNETT: I've put in the "Marked
22 Exhibits" folder Exhibit 88. If you -- your counsel
23 could look at that.

24 Let me know if you see that.

25 (Exhibit 88 was marked for identification 03:50:05

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1 by the court reporter and is attached hereto.)

2 MR. BROOKS: I do see it now.

3 BY MS. HARTNETT:

4 Q This is -- Dr. Levine, do you see -- this is
5 testimony that you gave to the Pennsylvania legislature 03:50:11
6 in March of 2020.

7 A Okay.

8 Q Do you recall giving this testimony?

9 A I recall testifying, yes.

10 Q Okay. I'm -- I have a question that -- you 03:50:19
11 had your kind of prepared remarks, and then you got
12 some questions from the legislators, and what I would
13 like to do is ask you about something on page 61, which
14 was your response to a question about puberty blockers,
15 if you could page forward to 61. 03:50:33

16 MR. BROOKS: Will you direct us to the
17 question?

18 Let me see here. I -- I --

19 MS. HARTNETT: Okay. If -- yeah. It's a
20 question from Representative Zimmerman, and it's asking 03:50:47
21 about the reversibility of puberty blockers, on
22 page 61.

23 MR. BROOKS: Oh, the question on 61 is
24 fragmentary; right?

25 "If puberty blockers are started," is that the 03:51:06

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1 question you're referring to?

2 MS. HARTNETT: You can feel free to look
3 above, but I'd like to ask about the passage on 61.

4 He asked a two-part question, and he had then
5 asked to be reminded about the second part of the 03:51:21
6 question.

7 And Representative Zimmerman said, "Yes. If
8 puberty blockers are started."

9 And then Dr. Levine said, "Oh, reversible,
10 yes, sorry." 03:51:30

11 And what I'd like to ask him is to read this
12 passage -- hear his testimony and just whether he
13 continues to believe what he's testified to.

14 THE WITNESS: I've read the paragraph.

15 MR. BROOKS: The -- 03:52:06

16 BY MS. HARTNETT:

17 Q I guess, just --

18 MR. BROOKS: Just continue --

19 THE WITNESS: Oh, you want me to continue?

20 MR. BROOKS: I want you to read to the end of 03:52:11
21 that answer.

22 MS. HARTNETT: Correct. Thank you.

23 THE WITNESS: Okay.

24 BY MS. HARTNETT:

25 Q Do you stand by the testimony that you gave in 03:52:32

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1 these two paragraphs?

2 A I don't see a -- a major difference between
3 what I just said to you except -- than what I said
4 here. Here, I was talking about one year. And -- and
5 it depends on -- you know, if you give a puber- -- an 03:52:51
6 eight-year-old child a puberty blocker versus a
7 nine-year-old child versus a 14-year-old child. I
8 think we're talking about different phenomenon, you
9 see. The -- not only biologic phenomenon, but
10 psychosocial phenomenon. Because if you give it to an 03:53:09
11 eight-year-old, their peers are still puerile, you see.
12 And -- and when -- if you give it to 14-year-old or a
13 12-year-old, their peers are rapidly growing and
14 changing and being involved in all kinds of
15 psychosocial and -- processes that -- that a 03:53:23
16 nine-year-old is not, the eight-year-old is not.

17 So I think today's testimony elaborates upon
18 what I was saying in a less sophisticated way to
19 Mr. Zimmerman.

20 Q Thank you. You talk about desistance at 03:53:37
21 length in your report; correct?

22 A I hope so, yes.

23 MR. BROOKS: Counsel, do you want me to take
24 down 88 or leave it up?

25 MS. HARTNETT: You can take down 88. 03:53:50

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1 BY MS. HARTNETT:

2 Q Do you believe that desistance should be the
3 goal of treating patients with gender dysphoria?

4 A I think I previously stated that the goal of
5 treating gender dysphoria is to have an informed 03:54:05
6 consent process in a brain -- for a person whose brain
7 is old enough to consider the possibilities about the
8 risks, and the goal of -- of their gender expression
9 has to rely primarily on them and their process of
10 coming to grips with what it needs, not just in 03:54:24
11 fantasy, but in reality, for them to portray themselves
12 as a trans person.

13 So I don't -- your question has previously
14 been answered by me. Parents would very much like me
15 to be able to return their child efficiently and 03:54:44
16 quickly to a tran- -- to a cis state, but I can't
17 promise that as a goal. I can't even hold that out as
18 a goal. What I hold out is what I just said to you.

19 Q If you could -- you -- so you don't believe
20 it's possible to talk somebody out of being 03:55:08
21 transgender; is that fair?

22 MR. BROOKS: Objection.

23 THE WITNESS: It's not the language that I
24 would ever use. I don't talk people out of things. I
25 don't talk people out of getting married to a person. 03:55:22

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1 I don't talk people out of going to this college versus
2 that college.

3 I -- I -- I sort of elicit their feelings. I
4 help them see where there is conflict. I help them
5 articulate the pluses and minuses, as we can predict 03:55:38
6 the future. I look at trends.

7 I don't talk people out. It's not what a --
8 what Dr. Levine, the psychiatrist, does, talk people
9 out of X, Y or Z. And Z may be transgender identity.

10 Q If you could treat everyone to have them cease 03:55:58
11 being transgender who -- sorry.

12 For the transgender patients you have, if you
13 were able to treat them such that they would no longer
14 be transgender, would that be your preferred outcome?

15 MR. TRYON: Objection. 03:56:19

16 THE WITNESS: It depends what cost it would
17 have to be -- to return to living as a cisgender
18 person. It would not be my goal if it would cost them
19 their sanity, for example, if it would cost them
20 continued anguish. My goal is -- is stated to -- I've 03:56:38
21 already stated my goal.

22 The -- there is a belief that life is hard
23 enough as a cisgender person, you see. But these
24 things -- you see, I -- I -- I'm interested in what it
25 is about being a cisgender person that is so hard for 03:57:08

1 you, you see. Why is it that this is so difficult for
2 you. What is it about femaleness or maleness or
3 your -- your -- your sex, your original sex, you know,
4 your sex, what it is about it that is so offensive and
5 offending to you. Why is there such incompatibility. 03:57:30
6 Tell me. Teach me.

7 Q But using the language from your -- at least
8 your declaration earlier in the case where you had
9 described, you know, the -- the risks and harms that
10 would come from, quote, putting a child or adolescent 03:57:44
11 on the pathway towards life as a transgender person --
12 I'm just trying to understand if -- if you, Dr. Levine,
13 could put all the young people that were experiencing
14 gender dysphoria on a pathway toward being
15 non-transgender, would you do that? 03:57:59

16 A What I would say about that, if I could put
17 them on a pathway of being non-transgender, I would
18 expect that the vast majority of them would end up to
19 be homosexual in their orientation. And the
20 cisgender with -- you know, if they were males, they 03:58:16
21 would probably be cisgender with a little feminine
22 aspects to them, but they would be homosexual. And if
23 they were biologic females, they would be cisgender
24 lesbians with a little touch of masculine patterns and
25 so forth. 03:58:35

1 So that would be cisgender to me, but I
2 wouldn't be cisgender heterosexual. I think we already
3 know scientifically the outcome of gender atypicality.
4 Cross-gender atypicality in boys and girls is
5 homosexual orientation. 03:58:52

6 Q Is it your opinion that it's better to be a
7 cisgender homosexual than a transgender heterosexual?

8 MR. BROOKS: Objection to the form of the
9 question.

10 THE WITNESS: Well, you do no harm to your 03:59:09
11 stability. You do no harm to your anatomy. You do no
12 harm to your physiology. In that sense, I think -- you
13 don't -- you don't risk any of the complications of
14 cross-sex hormones, and you don't risk any of the
15 complications of surgery. And I think it's probably -- 03:59:24
16 although I can't tell you the facts, but I do believe
17 it's probably easier to be a gay person in society than
18 to be a trans person. And I don't mean it's easy to be
19 any sexual minority in our society.

20 BY MS. HARTNETT: 03:59:43

21 Q Do you know what autogynephilia is?

22 A I -- I didn't understand what you just said.

23 Q Apologies. Do you know what autogynephilia
24 is?

25 A Yes. 03:59:56

1 Q What is autogynephilia?

2 A Well, "autogynephilia" is a word that means
3 love of the self as a woman. It's a characteristic of
4 internal life that was popular in the trans literature,
5 beginning in about 1988. It was a concept suggested by 04:00:11
6 Ray Blanchard of Toronto. It was a supposition that --
7 that autogynephilic trans people had a form of
8 paraphilia and that it -- I think it was a concept that
9 replaced pretty much the concept of fetishistic
10 transvestism that had existed since the 1900s, early 04:00:44
11 1900s.

12 So at about -- the trans community objected to
13 the idea of autogynephilia, very profoundly objected to
14 the idea.

15 Anne Lawrence, who is a transsexual 04:01:06
16 researcher, wrote a book on men who are trapped in
17 men's bodies, and it was all about gyne- --
18 autogynephilia, men who -- who recognized that they
19 were autogynephilic.

20 I recently had a patient who came to see me 04:01:15
21 because he couldn't find anyone who knew anything about
22 autogynephilia.

23 But I think you don't find that word used in
24 the literature -- in the modern literature anymore.

25 Because I think with 2011 standards of care, there was 04:01:29

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1 much less interest in the pathways to transgenderism
2 and more interest in the treatment of transgenderism,
3 and so it became too many advocates, politically
4 irrelevant and obnoxious to -- to even use the term
5 "autogynephilia." 04:01:55

6 Q Do you find autogynephilia to be a helpful
7 concept?

8 A For some people.

9 Q Have you ever heard it said that transgender
10 people are either gay, mistaken or have autogynephilia? 04:02:06

11 MR. BROOKS: Objection.

12 THE WITNESS: I don't recall hearing that
13 sentence before.

14 BY MS. HARTNETT:

15 Q Do you think that that -- is that something 04:02:19
16 that you would agree with, that being transgender --
17 people think that transgender are either gay, mistaken
18 or have another malady, like autogynephilia?

19 MR. BROOKS: Objection.

20 THE WITNESS: It's not something that I would 04:02:32
21 summarize by saying. Those three options seem
22 pejorative and unscientific.

23 BY MS. HARTNETT:

24 Q Do you think the term --

25 A I'm sorry, I -- I object to the idea of 04:02:50

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1 mistaken.

2 Q Do you think the term or that use of
3 autogynephilia is obnoxious?

4 A No.

5 Q Do you think that being transgender is a 04:03:07
6 paraphilia?

7 MR. BROOKS: Objection.

8 THE WITNESS: To the extent that -- to the
9 extent that autogynephilia is a paraphilia and that
10 some men develop a transgender identity as a 04:03:18
11 consequence of autogynephilic behaviors, that was --
12 that may be one pathway towards transgender identity.

13 But I wouldn't certainly -- I -- I certainly
14 would not say that at all transgenders or most
15 transgendered people are autogynephilic. 04:03:38

16 BY MS. HARTNETT:

17 Q I mentioned the -- one possible formulation
18 that people that are identifying as trans are just gay,
19 mistaken or have a malady like autogynephilia, and I
20 think you said that you took issue with the notion of, 04:03:55
21 among other things, the idea of it being a mistake; is
22 that fair?

23 A I -- yeah, I take -- I take issue with that,
24 yeah.

25 Q Why? 04:04:05

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1 A A mistake is something that a patient decides
2 after they've trans- -- detransitioned and they say it
3 was a mistake to do that.

4 It's not something I would say. I would say
5 that they -- they have a current gender identity, and 04:04:21
6 I'm not sure they're -- I'm not sure anyone's gender
7 identity is not going to evolve in some way in the
8 future. Especially I would like to say that about
9 young adolescents.

10 But please don't -- please don't quote me 04:04:38
11 because I have never authored that sentence.

12 Q Thank you. Do you think that transgender
13 identity is something that can be cured?

14 A Can be cured?

15 Q Yeah. 04:04:54

16 A Is that what you said?

17 MR. BROOKS: Objection.

18 BY MS. HARTNETT:

19 Q Cured.

20 A If you read the end of my paper on the patient 04:05:02
21 who trans- -- detransitioned 30 years ago, I think I
22 said something like even though medical psychiatric
23 knowledge does not know how to transform a person from
24 a trans state to a cis state or a previous state, it
25 doesn't mean that life doesn't transform people into 04:05:25

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1 detransitioned people.

2 We need to understand the modesty and the
3 differences between what we know how to do to create
4 behavioral change, which is quite modest throughout
5 psychiatry and what happens to people over time if we 04:05:44
6 take a life course perspective.

7 So my case illustration in that case was
8 Dr. Levine did not change his -- did not cause his
9 detransition at all; right? Life processes, which he
10 described in great detail in the that paper, changed, 04:06:02
11 and it took him years to make that change, years of
12 anguish, years of the sense of inauthenticity as a
13 woman, which at first he tried to deny.

14 So I would -- I would refer you to the last
15 paragraph in that paper if you wanted to find out how I 04:06:22
16 said it. I can't -- I can't quote it. I'm just
17 paraphrasing it if for you.

18 Q But is that an example of someone that you
19 think was cured?

20 MR. BROOKS: Objection. 04:06:41

21 THE WITNESS: It was an example of a person
22 who changed their presentation and now is terribly
23 embarrassed about what he had -- I can call him "he"
24 now -- what he had done, or what she had done; right?

25 And now -- and it is now a person who -- I think I'm 04:06:57

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1 quoting -- hates all the advocates of the -- in the
2 trans world for, he believes, misleading people that
3 they can have a happy life.

4 But that's just one person's opinion, you
5 know. 04:07:13

6 But if you read the paper, I think, you know,
7 there's lots to think about in the paper.

8 Q Is it embarrassing to be transgender?

9 A In -- in some settings, it probably is, yes.

10 Q Do you think that transitioning, for a 04:07:28
11 transgender person, is something that you find to be an
12 embarrassing concept?

13 A No.

14 Q Well, you said that your -- I'm just -- I'm
15 not putting your patient's words in your mouth, but you 04:07:38
16 were describing him as having been embarrassed by the
17 whole thing. I -- I took that to mean he was
18 embarrassed by having transitioned; is that right?

19 A Yes, he's now angry at himself and angry at
20 those who facilitated his original transition. 04:07:52

21 But that's one person, you know.

22 Q But do you feel embarrassment for your
23 patients that have to go through transition?

24 MR. BROOKS: Objection.

25 THE WITNESS: Do I feel embarrassment? No. I 04:08:09

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1 feel --

2 BY MS. HARTNETT:

3 Q I'm just --

4 A No. That's -- that would not describe a

5 dominant feeling I have. I have concern for my 04:08:20

6 patient. I have worry about this, but I'm not

7 embarrassed by it.

8 Q Is shame one of the feelings?

9 MR. BROOKS: Objection.

10 Of whom? 04:08:35

11 BY MS. HARTNETT:

12 Q Do you (technical difficulty) shame for them?

13 MR. BROOKS: Objection.

14 THE WITNESS: I'm a little hard of hearing,
15 and I actually could not discern what you said. 04:08:43

16 BY MS. HARTNETT:

17 Q Sorry, I'll speak up.

18 I was asking if you felt shame for your
19 patients experiencing transition.

20 A No, I'm not -- am I ashamed? 04:08:52

21 Q Yes.

22 A No.

23 Q Do you think that people can change their
24 sexual orientation?

25 MR. BROOKS: Objection; outside the scope of 04:09:10

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1 this witness's testimony.

2 THE WITNESS: I think the work of Lisa Diamond
3 has demonstrated that among women who are -- who assert
4 a lesbian identity, that that lesbi- -- there is a lot
5 of two-way traffic between a heterosexual identity and 04:09:43
6 a homosexual identity, or orientation, we would say,
7 and -- so I don't know how to change a person's sexual
8 orientation, but I do think, especially among natal
9 women, sexual orientation is -- people experiment with
10 different ways of life and that there are -- there's 04:10:06
11 more two-way traffic between lesbian and a heterosexual
12 life among women. There's much more bisexual behavior
13 and bisexual eroticism among natal born females than
14 there is among natal born males.

15 So that would be my answer to your question, 04:10:29
16 without a yes-or-no answer.

17 Q Do you agree that gay people, on average, have
18 a harder time than straight people, on average, just
19 navigating life?

20 A Yes. 04:10:40

21 MR. BROOKS: Objection.

22 BY MS. HARTNETT:

23 Q Do you have similar views to those you've
24 expressed about caution before encouraging youth to be
25 transgender -- or to inhabit their transgender gender 04:10:51

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1 identity? Do you have similar views about youth
2 expressing homosexuality?

3 A No.

4 Q Why not?

5 A Well, again, I think I'm going to make a 04:11:03
6 distinction between homosexuality as it occurs in men,
7 as it occurs in women, and the eroticism of a person is
8 a bunch of fantasies and thoughts and attractions that
9 makes sex comfortable or anxious and makes romance easy
10 or hard to -- to participate in, and given the power of 04:11:37
11 orientation, I believe that people have to come to
12 grips with -- with who they are attracted to and -- and
13 what is easy for them and what is difficult for them.

14 And so I just think that that's part of the
15 human landscape and that people can -- can -- they 04:12:03
16 know -- they know their orientation, and then they have
17 to choose how -- how to act or not act on their
18 orientation, and it's a very personal, private and
19 often difficult decision, and I respect that, and I'm
20 happy to hear about it when it comes up in my gay 04:12:23
21 patients.

22 And, you know, I see a lot of people who have
23 orientations that are not heterosexual.

24 Q I'm just curious why the same principle
25 doesn't hold for people that have a gender identity of 04:12:37

1 transgender, if they have an innate sense that that's
2 their identity, why would you not approach that the
3 same way you approach homosexuality.

4 MR. BROOKS: Objection.

5 THE WITNESS: Because homosexuality does not 04:12:51
6 involve the -- it's not against the first principle of
7 medical ethics; above all, do no harm.

8 It doesn't involve changing the body's
9 reproductive capacity. It doesn't change the body's
10 sexual physiology, you see. It doesn't change the 04:13:08
11 ability to find a love partner, a stable mate. It --
12 it -- it doesn't -- trans- -- we're talking about here
13 changing the anatomy, changing the physiology, creating
14 the inability to have a child, interfering with the
15 ability to have sexual pleasure as we understand it in 04:13:32
16 the general population as, you know, orgasm.

17 So -- so we understand -- transsexuality is
18 exposing yourself to surgical complications. And
19 surgical transformation of a teenager, before a child
20 has lived long enough to -- to come to grips with the 04:13:51
21 multiple dimensions of being an older person, that is,
22 a 20-year-old or a 19-year-old, and romance and so
23 forth, that's why it's different. It's not the same.

24 You're trying to take a principle and -- and
25 apply it to a group of people that -- that you're 04:14:10

1 talking about the possibility of harming them. Not
2 just their -- their -- their reproductive capacity, but
3 harming them in numerous ways. And they have to take
4 responsibility for that choice, and they -- I just have
5 been saying all morning and all afternoon, I just want 04:14:29
6 them to be informed.

7 And, you know, 13-year-old passionate kids
8 cannot be informed easily.

9 Q I'm glad you brought that up.

10 Could you turn to paragraph 202 of your 04:14:49
11 declaration, page 69.

12 MR. BROOKS: Yeah. And it was long. I didn't
13 think it was that long.

14 Page 69. Let's see here.

15 You said 202. Yes, we have that on the 04:15:13
16 screen.

17 BY MS. HARTNETT:

18 Q Yeah, I wanted to ask you, these are within a
19 larger section, well, about various harms that come
20 from, I guess, treating or -- or validating a 04:15:26
21 transgender person's identity. But this paragraph 202
22 talks about harm to family and friendships, and then
23 203 talks about sexual-romantic harms.

24 Do you see that?

25 A Yes. 04:15:41

1 Q And my question is, the harms you set forth in
2 these paragraphs -- first of all, you cite your -- only
3 your own publications for these two paragraphs; is that
4 correct?

5 A Yes, it's my only citation. 04:15:49

6 Q Is there any other basis for these assertions?

7 A Well, there's an article in the Archives of
8 Sexual Behavior about being the fetish object, when --
9 a transsexual adult talking about -- a survey of
10 transsexual adults, that they get really upset that 04:16:10
11 people want to have sex with them because they're what
12 they call a fetish object, that they're -- they -- they
13 have attractions to transsexuals and they want to have
14 an experience.

15 And so it's really about the frustration of 04:16:25
16 adult tran- -- sexually active transsexual, I think --
17 transsexuals who are complaining about difficulties in
18 romantic relationships because they feel they're being
19 used by people with perverse adventures, some
20 curiosities, as opposed to genuine romantic 04:16:47
21 relationships.

22 So I was happy to read that article because it
23 had confirmed one of the stories that I had been
24 hearing from many patients over the years by --

25 Q Can you direct me -- 04:17:00

1 A Sorry.

2 Q What article is that? Can you direct me --

3 A I -- I certainly can get you the reference.

4 It's in the Archives of Sexual Behavior. It's probably

5 within the last two years. And I think the first 04:17:13

6 author's name is either -- starts with an A, B or C.

7 Anyway, I -- you -- it's about tran- -- in the

8 title, there's something like "transgender and fetish

9 objects." So I --

10 Q Okay. 04:17:38

11 A I can -- if you want, I will eventually give

12 you the exact reference, yeah, but --

13 Q That's --

14 A -- you're -- you're not interested in wasting

15 time, I'm sure. 04:17:48

16 Q No, no, I -- I -- I just want to know the

17 basis for these -- these paragraphs, so I appreciate

18 you telling me that.

19 My question is -- you know, I read 202 and

20 203, and you say -- you list various perceived harms 04:17:58

21 and challenges from being transgender; is that fair?

22 A Yes.

23 Q What I'm confused about is, is this premised

24 on the notion that there's a way to dissuade someone

25 from being transgender so that they don't have these 04:18:14

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1 outcomes?

2 A Exactly. I -- this is what I'm trying to do.

3 This is why I say to parents, you know, we have to

4 support and love this child regardless of what --

5 what -- what they pass through because mental health is 04:18:35

6 determined, in part, by the ability to -- to be valued

7 by your family before you can be valued by other

8 people.

9 And I think the outcomes -- I mean, so many of

10 my patients have in fact been alienated from their 04:18:53

11 families. And -- sorry -- you've heard about runaway

12 kids and throwaway kids and -- and I --

13 Q Well, why isn't -- sorry, why isn't that

14 the family's --

15 MR. BROOKS: Counsel -- Counsel, the witness 04:19:08

16 is busy talking, in the middle of his --

17 MS. HARTNETT: Yeah, I'm aware of that, but

18 he's also taking a long time to respond to

19 straightforward question.

20 BY MS. HARTNETT: 04:19:18

21 Q My question is whether or not --

22 MR. BROOKS: Counsel, the witness is entitled

23 to finish his answer.

24 MS. HARTNETT: He's not entitled to

25 filibuster. 04:19:23

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1 MR. BROOKS: He's not filibustering; he's
2 answering your question.

3 MS. HARTNETT: I've been very permissible all
4 day with his answers, but I'm happy to have him finish
5 his answer.

04:19:35

6 MR. BROOKS: Thank you.

7 If you have -- if you feel that you haven't
8 finished, you may finish.

9 THE WITNESS: I have heard considerable
10 stories over the years about family relationships,
11 about alienations, about isolation. And in answer to
12 your question, in -- in hearing those stories, it has
13 led me to counsel both the patient and the parents to
14 do whatever they can to maintain their relationships,
15 despite what the child or the grownup, the adult, has
16 decided because I know the suffering of mothers and
17 fathers and grandmothers and grandfathers and of
18 patients.

04:19:43

19 And so it's an adverse outcome to have family
20 alienation. And from the very beginning, I say the
21 first principle evaluation is to preserve family
22 relationships, and I think you can read that in my 2021
23 paper.

04:20:19

24 BY MS. HARTNETT:

25 Q My question is -- so in the example of the

04:20:31

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1 child who's -- or the adolescent who's experiencing
2 gender dysphoria and would like to be affirmed and the
3 parents that are horrified, why isn't the answer to try
4 to work with the parents to be more tolerant and
5 understanding rather than to try to change the child? 04:20:48

6 A I think I do work with the parents. I do.
7 But it's not an either-or thing. It's not an either-or
8 phenomenon.

9 And just because --

10 Q Is your -- 04:21:07

11 A Just because we work with a parent doesn't
12 mean I'm capable of changing the parent's behavior,
13 changing the parent's values, changing the parent's
14 knowledge of the child and changing the parent's fear
15 for their future. 04:21:22

16 Q I'm just puzzled by these paragraphs because
17 it strikes me that the person is going to be
18 transgender regardless if they get transgender
19 healthcare and, therefore -- I don't understand the
20 point that giving them healthcare is going to harm them 04:21:37
21 more than they would have otherwise been harmed if they
22 were transgender, but just without healthcare.

23 MR. BROOKS: Objection; assumes facts not in
24 evidence, argumentative.

25 THE WITNESS: I accept the fact that you don't 04:21:47

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1 understand.

2 BY MS. HARTNETT:

3 Q Can you explain to me why -- so, I guess --
4 let me ask you this: Do you disagree that these people
5 are transgender even if they don't get the healthcare? 04:21:56

6 MR. BROOKS: Objection.

7 THE WITNESS: I agree that the patient who
8 says that "I'm transgender" is currently transgender.
9 That's what I believe. They're currently transgender.

10 Do I believe they will always be transgender? 04:22:14

11 No.

12 Can I predict which ones will be transitioned
13 and not? Not -- not with any certainty, no.

14 But, you see, I believe that many of the
15 assumptions behind your questions is that 04:22:28
16 transgenderism is a fixed phenomenon, it never changes,
17 and I -- if I am correct that that is your assumption,
18 then you and I disagree.

19 BY MS. HARTNETT:

20 Q And do you agree that there's no evidence 04:22:44
21 to -- assuming those are different assumptions, that
22 there's not evidence out there that would prove either
23 of us correct on that one?

24 MR. BROOKS: Objection.

25 THE WITNESS: No, I don't agree with that at 04:22:53

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1 all. Not at all.

2 BY MS. HARTNETT:

3 Q Do you believe that --

4 A I -- and -- and I give you evidence of

5 detransition. 04:22:59

6 Q Is there anything other than anecdotal
7 evidence to say whether or not gender identity is fixed
8 versus not labeled?

9 MR. TRYON: Objection.

10 THE WITNESS: You know, you and I have 04:23:13
11 different ideas of what is anecdotal.

12 Is Lisa Diamond's work anecdotal, about
13 homosexuality? Is that anecdotal?

14 And -- and, you know, there is something
15 called a proof of concept study that if you can 04:23:29
16 demonstrate that it is possible, for example, to cure a
17 particular cancer with a new drug that has never been
18 tried before, that proof of concept then leads to more
19 definitive studies.

20 And we're in -- we're -- we already have proof 04:23:47
21 of concept that -- that there are many people who
22 detransition.

23 In fact, if you look at the UK studies, the
24 two UK studies that have been done in the last, I
25 think, six months, we all now have a rate of 04:24:07

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1 detransition. We now, for the first time, have a rate
2 of detransition data.

3 And so I would say it's not anecdotal.
4 It's -- it's an emerging new branch of transgender
5 science, so to speak, or knowledge that the error rate 04:24:24
6 in trans -- in -- in -- in affirmative care is now
7 becoming more clear than it ever was.

8 Q You are aware that some transgender -- many
9 transgender people have fulfilling romantic
10 relationships and family relationships; correct? 04:24:37

11 MR. BROOKS: Objection.

12 THE WITNESS: I am aware.

13 BY MS. HARTNETT:

14 Q In paragraph 203, you say (as read):
15 After adolescence, transgender 04:24:47
16 individuals find the pool of
17 individuals willing to develop a
18 romantic and intimate relationship
19 with them to be greatly diminished."

20 A Yes. 04:24:57

21 Q Do you have any basis for making that
22 statement other than your own anecdotal experience?

23 A Well, if you look at -- if you look at
24 cross-sectional data about the percentage of people who
25 are married and cohabitating among trans people versus 04:25:09

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1 cis people, there are -- there are far less marriages,
2 and there are far less stable relationships.

3 If you look at a series of psychosocial
4 histories of -- of patients, many of them do not come
5 to us with stable functional relationships. I don't -- 04:25:31

6 Q You --

7 A I actually -- I actually don't think this
8 is -- this is anecdotal, but it is perhaps
9 impressionistic based upon 50 years of taking care of
10 these people. 04:25:50

11 Q Is it possibly also dated?

12 MR. BROOKS: I'm -- I'm sorry, I couldn't hear
13 the question.

14 BY MS. HARTNETT:

15 Q Is the notion also possibly dated? 04:25:57

16 A Well, the big hope in the trans advocate
17 community has been as society improves, the lives --
18 society recognizes and accepts transgender people,
19 there will be less suffering and less isolation in
20 trans people. That -- that is -- you can find that in 04:26:15
21 many, many studies that -- that articulate the -- the
22 frequency of psychiatric problems. And there's the
23 hope that as -- the whole idea of the minority stress
24 theory is that if we improve society, fewer people will
25 suffer. 04:26:40

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1 I don't know whether that -- I hope it's true
2 that as society has improved its defense of -- of
3 gender diverse people, that more gender diverse people
4 will be able to have satisfying, intimate, stable
5 relationships. I hope that is true. And I hope it 04:26:56
6 will be worked through in ten years.

7 Q Thank you. In the paragraph 202, you say, in
8 the middle of that paragraph (as read):

9 "By adulthood, the friendships of
10 transgender individuals tend to be 04:27:11
11 confined to other transgender
12 individuals (often 'virtual' friends
13 known only online) and the generally
14 limited set of others who are
15 comfortable interacting with 04:27:24
16 transgender individuals."

17 Do you see that?

18 A Yes.

19 Q Is there a basis for that beyond your own --
20 you cite yourself for that, but are you aware of 04:27:39
21 whether or not that actually represents the lived
22 experience of transgender individuals in 2022?

23 A Well, I think in that sentence, if I could
24 edit it, I would emphasize rather than "by adulthood,"
25 I would say "during adolescence." And the basis is not 04:28:00

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1 just my clinical experience. The basis is the clinical
2 experience of the people in the psychosocial therapy
3 group that I mentioned earlier this morning. That
4 seems to be a broad consensus, that many of their trans
5 people are -- have social isolation problems in their 04:28:19
6 friendships and their romances, and I've seen this in
7 my practice. They really are occurring through --
8 through the Internet.

9 And when they're not occurring through the
10 Internet, they're occurring with people in the sexual 04:28:34
11 minority community, other people who may not be trans
12 themselves, but who are excited by their trans and
13 supportive of their trans status.

14 So that's the basis of it.

15 Q You've referred to the trans community, at 04:28:53
16 times, in our conversation today; correct?

17 A I'm sure I've said that, yes.

18 Q Are you aware that the trans community, as a
19 general matter, takes issue with your viewpoint?

20 MR. BROOKS: Objection. 04:29:08

21 THE WITNESS: Yeah, I am aware that there are
22 members in the trans community who find me a hateful
23 person and who believe that I'm against medical,
24 surgical and social care and against the civil rights
25 of transgender people. 04:29:28

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1 I can't control what they believe about me,
2 you see. But I am aware that some people are very
3 appreciative of me and other people think I'm an enemy.

4 BY MS. HARTNETT:

5 Q If 95 percent of trans people opposed your 04:29:47
6 methods, do you think that they would make sense to
7 continue suggesting them for trans people?

8 MR. BROOKS: Objection --

9 THE WITNESS: What was the --

10 MR. BROOKS: -- lack of foundation, calls for 04:29:56
11 speculation.

12 THE WITNESS: What was the last part of your
13 sentence?

14 BY MS. HARTNETT:

15 Q I'm just trying to ask you if -- like, say, 04:30:04
16 assuming 95 percent of trans people opposed your
17 methods, would you have concern for continuing to
18 promote them?

19 MR. BROOKS: Objection.

20 THE WITNESS: To promote my methods? 04:30:13

21 BY MS. HARTNETT:

22 Q Towards --

23 MR. BROOKS: Objection.

24 BY MS. HARTNETT:

25 Q -- trans people. 04:30:17

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1 A My method of -- of informed consent and my
2 method of -- of being thoughtful and considerate
3 about -- about -- about the sources and the
4 consequences?

5 I don't believe that -- that a person 04:30:32
6 thinks -- misunderstands my position would make me give
7 up my position. If you show me that -- that my
8 position is not tenable in a -- in a -- in a -- in a
9 strong scientific basis, I'm certainly able to change.

10 The fact that public opinion, in some 04:30:53
11 commun- -- some sectors of the community, you know,
12 think -- misunderstand me and -- and don't really know
13 what I'm saying, you see, that -- that wouldn't make me
14 give it up.

15 And I don't know how you could assume that 04:31:09
16 95 percent of people, you see. I don't know -- you're
17 just presuming things.

18 Q Are you opposed to civil rights for
19 transgender people?

20 A Absolutely not. I am not -- 04:31:20

21 Q Do you understand --

22 A I am not --

23 Q Sorry?

24 A -- opposed to civil rights for transsexual
25 people. 04:31:26

1 BY MS. HARTNETT:

2 Q Do you object to your opinion being used to
3 deny an 11-year-old girl the ability to run on a track
4 team at her middle school in West Virginia when she's
5 already otherwise socially transitioning and is 04:32:26
6 supported by her family and her school?

7 MR. BROOKS: Objection; mischaracterizes the
8 witness's opinions.

9 THE WITNESS: I've heard the objection that
10 you're -- you're mischaracterizing my opinion. 04:32:41

11 I -- I don't understand.

12 My opinion has to do with the things I've
13 testified to. I did not testify to anything about an
14 11-year-old girl.

15 And what you are telling me about, I trust 04:32:54
16 you're telling me the truth.

17 I actually don't think about -- when I think
18 about civil rights, I am thinking much more about, I
19 think, older people, you know, housing, educational
20 discrimination in colleges and things like that, 04:33:18
21 vocation, right to vote.

22 You will have to -- it's a -- it's a new thing
23 for me to even think about the civil rights of a
24 six-year-old or a seven-year-old or an eight-year-old.

25 ///

1 BY MS. HARTNETT:

2 Q Well, your -- I'll help you.

3 Your opinion was also submitted in the case of
4 Lindsay Hecox, a college student who was seeking to run
5 consistent with her identity, gender identity, on her 04:33:39
6 college cross-country and track team.

7 A Yes.

8 Q You're aware that your -- your testimony was
9 submitted in support of prohibiting her from running on
10 the team? 04:33:51

11 MR. BROOKS: Objection; mischaracterizes that
12 case.

13 THE WITNESS: Again, my testimony --

14 MS. HARTNETT: I'm counsel of record in that
15 case, and I can tell you that I'm accurately 04:34:03
16 characterizing the case, which is that Dr. Levine's
17 declaration was submitted in support of a motion to
18 ban -- to -- to uphold a statute that would not permit
19 Lindsay Hecox to run, consistent with her gender
20 identity, on a college sports team. 04:34:15

21 And I'm asking him, in light of his statement
22 that he does not oppose transgender civil rights, how
23 he can reconcile that with having his testimony used in
24 this manner.

25 MR. BROOKS: Objection; argumentative. 04:34:26

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1 The witness has explained that his opinions
2 are about science.

3 MS. HARTNETT: Please stop testifying.

4 MR. BROOKS: Please stop arguing.

5 BY MS. HARTNETT: 04:34:35

6 Q Dr. Levine, how can you reconcile --

7 (Simultaneous speaking.)

8 MR. BROOKS: This is not a debate. This is a
9 deposition.

10 MS. HARTNETT: And this -- you're not the 04:34:45
11 witness, either. I'd like to ask Dr. Levine and get an
12 answer as to how he can reconcile having his testimony
13 be filed to oppose the participation of a college
14 student on her college team consistent with her gender
15 identity. 04:34:59

16 THE WITNESS: I don't find it easy to
17 reconcile -- this is just part of some of the great
18 conflict embedded in -- in -- my -- my knowledge is
19 about science. And I do recognize that people
20 interpret what I say in various ways and -- but I don't 04:35:25
21 think I'm responsible for how that is interpreted. I'm
22 just making statements based on my knowledge, based on
23 my clinical experience. And I am uncomfortable, at
24 times, with various aspects of what people make of --
25 of what I have said. 04:35:46

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1 I -- I am uncomfortable, to some extent, by
2 how the lawyers have used some of my -- you know, at
3 times. And I am certainly uncomfortable at how the
4 trans community has used some of what they think I
5 stand for.

04:36:04

6 I'm trying to be clear what I -- what I think
7 and what I stand for. And I am somewhat uncomfortable,
8 at times, about many things, including this, but --

9 BY MS. HARTNETT:

10 Q Do you understand that you're being paid as an 04:36:16
11 expert witness in both the Hecox case and in this case
12 by the defendants in order to submit testimony that
13 will be used against the participation of the
14 transgender students?

15 MR. TRYON: Objection. 04:36:31

16 THE WITNESS: I don't think I fully understand
17 that. I don't think -- I don't think that's -- I -- I
18 guess the answer to the question is I don't fully
19 understand it.

20 BY MS. HARTNETT: 04:36:48

21 Q Okay. Because I -- I'm -- I'm genuinely
22 perplexed because you've said that you're supporting
23 transgender civil rights and you wish for a time where
24 there's less discrimination and that -- yet your
25 submission is not being submitted in a neutral manner 04:36:59

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1 in this case; it's being submitted in support of the
2 side of the case that's seeking to defend the exclusion
3 of the transgender student.

4 And so we don't need to belabor the point, but
5 I'm just trying to -- I'm happy to tell you that. And 04:37:11
6 if you have something you would like to say on the
7 record as to how you can reconcile the use of your
8 testimony for that, with the views you've expressed in
9 this deposition about seeking to make the world better
10 for transgender people, I would appreciate your chance 04:37:24
11 to respond to that.

12 MR. BROOKS: Objection; mischaracterizes --

13 MR. TRYON: Objection.

14 MR. BROOKS: -- testimony and is outside the
15 scope of this witness's expert opinions. 04:37:30

16 THE WITNESS: Well, I thank you for pointing
17 that out. I will think about it more.

18 MS. HARTNETT: Thank you.

19 I think we can take a break now.

20 THE VIDEOGRAPHER: We are off the record at 04:37:46
21 4:38 p.m.

22 (Recess.)

23 THE VIDEOGRAPHER: We are on the record at
24 4:55 p.m.

25 MS. HARTNETT: Thank you. 04:55:19

1 BY MS. HARTNETT:

2 Q Hi, Dr. Levine. We discussed the SEGM
3 organization earlier.

4 Do you recall that?

5 A I do. 04:55:25

6 Q And you described it as an evidence-based
7 organization; correct?

8 A Yes. That's the title, yes.

9 Q And you view them as an organization that
10 strictly adheres to the facts; correct? 04:55:35

11 A Well, facts are interpreted, but, yes, they
12 have a basis in facts.

13 Q In January, you earlier, in the deposition,
14 mentioned that you did a podcast; correct?

15 A I did. 04:55:53

16 Q And that podcast was with two of the lead
17 advisors of SEGM; is that right?

18 A I don't think they're the lead advisors.
19 They're -- they were members of the psychotherapy
20 group. I don't -- I don't -- I wouldn't describe them 04:56:10
21 as lead advisors to SEGM, no.

22 Q Okay. They're -- are they affiliated with
23 SEGM in some way?

24 A They're members of SEGM, yeah.

25 Q And that would be Sasha Ayad and Stella 04:56:21

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1 O'Malley; is that right?

2 A Yes.

3 Q Were the thoughts that you shared with them
4 during that podcast all truthful?

5 A I hope so. 04:56:32

6 Q Okay. I'm just going to -- and I referenced,
7 before we went on the record, uploading a few audio
8 files. I've excerpted some excerpts from the talk you
9 gave, which was, for the record, available at
10 [https://gender-a-wider-lens.captivate.fm/episode/60-](https://gender-a-wider-lens.captivate.fm/episode/60-pioneers-series-we-contain-multitudes-with-Stephen) 04:56:53
11 [pioneers-series-we-contain-multitudes-with-Stephen](https://gender-a-wider-lens.captivate.fm/episode/60-pioneers-series-we-contain-multitudes-with-Stephen) --
12 [S-T-E-P-H-E-N](https://gender-a-wider-lens.captivate.fm/episode/60-pioneers-series-we-contain-multitudes-with-Stephen) -- Levine, dated January 28th, 2022.

13 Dr. Levine, do you recall whether the podcast
14 was -- the conversation you had with Ms. O'Malley and
15 Ms. Ayad actually took place on January 28th? 04:57:38

16 A I think it did, yes.

17 Q Okay. So I'm going to just play for you an
18 excerpt, and I'll ask you a question about it.

19 MS. HARTNETT: Could you please play
20 Exhibit 89. 04:57:56

21 (Exhibit 89 was marked for identification
22 by the court reporter and is attached hereto.)

23 THE WITNESS: I'm not hearing anything.

24 THE VIDEOGRAPHER: Just -- just a moment. I
25 believe he's working on it. 04:58:22

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1 MR. REISBORD: Were you unable to hear that?

2 THE VIDEOGRAPHER: Correct.

3 MS. HARTNETT: We did not hear that.

4 MR. REISBORD: Let my try one more time.

5 (Video Clip Played.) 04:58:40

6 "In 1973" --

7 MR. REISBORD: Are you able to hear that?

8 MS. HARTNETT: Yes.

9 THE WITNESS: Yes.

10 MR. REISBORD: Okay. 04:58:45

11 (Video Clip Played.)

12 "In 1973, after 30 days in -- in practice, I

13 was at a department of psychiatry and had a halftime

14 private practice. I got a man who told me he was

15 sitting in the backyard with a gun in his mouth, under 04:59:00

16 his oak tree, and he decided either to kill himself" --

17 MS. HARTNETT: We can't hear it anymore.

18 (Video Clip Played.)

19 -- "see a psychiatrist who used to be my

20 supervisor a month ago, and my supervisor said, Well, 04:59:17

21 there was an expert in human sexuality down at the

22 university. Why don't you go see him?

23 "And that was the beginning of my career

24 working with people who wanted to change their sex.

25 "You know, he almost killed himself at that 04:59:33

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1 point in 1973."

2 BY MS. HARTNETT:

3 Q Dr. Levine, was that the patient that you were
4 referring earlier to in the deposition?

5 A Yes. 04:59:48

6 Q Rutherford or Ruth; correct?

7 A Yes.

8 MS. HARTNETT: Could you play tab 40, please.

9 MR. REISBORD: Tab 40 would be Exhibit 90.

10 MS. HARTNETT: Oh, sorry, thanks. 05:00:07

11 (Exhibit 90 was marked for identification

12 by the court reporter and is attached hereto.)

13 (Video Clip Played.)

14 "And -- and nine years later, he in fact did
15 kill himself after he changed his gender and left his 05:00:11
16 family and left his country and then returned back to
17 live in America and just decided to end his life. So
18 that was my introduction, my nine-year introduction, to
19 adults who wanted to change their sex.

20 "This was a highly accomplished man. He was 05:00:30
21 the head of our county library system. He had a degree
22 in divinity. And he was a joy to talk to. And he --
23 one day, about four years before he actually killed
24 himself, he slashed his -- at his neck, and when he was
25 admitted to the hospital, he -- he told me that I was 05:00:55

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1 deficient as a therapist because I failed to
2 investigate how angry he has been all of his life at
3 his parents."

4 BY MS. HARTNETT:

5 Q Dr. Levine, is what was just played an 05:01:10
6 accurate account of -- I'm sorry, is -- is what -- do
7 you stand by the account that you provided to SEGM, as
8 just played in that sequence?

9 MR. BROOKS: Objection to the description.

10 THE WITNESS: Are you asking if -- if -- if I 05:01:28
11 said these things that you're recording --

12 BY MS. HARTNETT:

13 Q Yeah, thank you, I'll ask a better question.

14 Is that what you said on the SEGM podcast
15 earlier this year? 05:01:40

16 A I don't call this "the SEGM podcast." This is
17 a --

18 Q I'm sorry.

19 A -- podcast of these two women who have a
20 business in providing information to others who are 05:01:47
21 interested.

22 So I --

23 Q Okay.

24 A -- did say these things, as you -- as is
25 obvious, I said these things. 05:01:56

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1 Q And they were truthful; correct?

2 A Was I telling the truth? Yes --

3 Q Yes.

4 A -- I was -- I tell --

5 Q Okay. 05:02:06

6 A -- the truth.

7 Q Sorry, it's partially a formality of -- I'm
8 just trying to confirm that what you were saying to
9 them is also true today, and so that's why I'm asking
10 you the question, but I won't refer to it as "the SEGM 05:02:17
11 podcast."

12 MS. HARTNETT: Could you please play tab 41,
13 Exhibit 91.

14 (Exhibit 91 was marked for identification
15 by the court reporter and is attached hereto.) 05:02:24

16 (Video Clip Played.)

17 "It was quite an educational experience for
18 me, both as a he and as a she, and -- and she and I
19 wrote a paper in the Archives of Sexual Behavior in
20 19-, I think, -83 called Increasingly Ruth: Towards an 05:02:37
21 understanding of sex reassignment surgery.

22 And then in 1984, when he died, I wrote a
23 letter to the editor about Ruth's suicide.

24 Q Dr. Levine, was that a recording of you
25 speaking to the podcast earlier this year? 05:03:03

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1 A Yes.

2 Q You mentioned that you wrote a letter to the
3 editor after Ruth's death, and in that letter, you said
4 that Ruth's unfortunate legacy to those who invested in
5 her is psychologic injury due to her abandonment of 05:03:18
6 them; is that correct?

7 A Would you repeat that? I don't recognize
8 those words.

9 Would you repeat them slowly?

10 Q I'm sorry. Ruth's unfortunate legacy to those 05:03:30
11 who invested in her is psychologic injury due to her
12 abandonment of them.

13 A Yes, that was --

14 Q Did you write that?

15 A Yes. I don't want to give you more 05:03:39
16 information than you're asking for, but -- the answer
17 to your question is yes.

18 Q Thank you.

19 MS. HARTNETT: Could you play tab --

20 Exhibit 92, please. 05:04:01

21 (Exhibit 92 was marked for identification
22 by the court reporter and is attached hereto.)

23 (Video Clip Played.)

24 "So I've been accused of being very
25 conservative on this issue and biased by -- by that 05:04:06

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1 experience, and, in fact, I plead guilty. I am -- I --
2 I -- that was my introduction."

3 Female: "Yeah."

4 "And it -- and, unfortunately, it's not the
5 only case of -- of people who have aspirations who 05:04:21
6 think that their troubles as a person will disappear
7 if -- if they change their gender presentation and
8 change their bodies and -- and only to discover that
9 life is not as easy as they imagined, and they didn't
10 escape much. 05:04:44

11 "So I plead guilty to being biased, and I
12 think all of us have a kind of bias, and we ought to
13 own it."

14 BY MS. HARTNETT:

15 Q Dr. Levine, were those your statements on the 05:04:55
16 podcast earlier this year?

17 A Yes.

18 Q And were they your truthful statements?

19 A Yes.

20 MS. HARTNETT: Could you please play 05:05:10
21 Exhibit 93.

22 MR. TRYON: This is Dave Tryon. I'm going to
23 object to --

24 (Video Clip Played.)

25 "I have a Mas-" -- 05:05:16

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1 MR. TRYON: I'm going to object to to playing
2 these excerpts without the full context.

3 MS. HARTNETT: And I will just say for the
4 record that there is -- I think the -- the person that
5 gave the podcast knows the context, and I've given the 05:05:26
6 web URL for anyone to look at the full context.
7 There's not a written transcript online.

8 MR. TRYON: My objection stands.

9 MS. HARTNETT: Of course. Thank you.

10 Could you play Exhibit 93, please. 05:05:43

11 (Exhibit 93 was marked for identification
12 by the court reporter and is attached hereto.)

13 (Video Clip Played.)

14 "I have a Master's prepared person, just got
15 out of her -- her internship, who told me how you're 05:05:48
16 supposed to treat transgender people, and I was just
17 astounded.

18 "I gave a seminar two years ago to residents
19 who told me -- residents in psychiatry -- who told me
20 how trans people ought to be treated. 05:06:05

21 "See, they had a chain in trust. Somebody
22 taught them, and they believe it, the passion, they
23 believe it. They have the zeal of the new -- of the
24 convert to being a psychiatrist or being a counselor,
25 whatever it is. And -- and -- and when I give them 05:06:21

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1 facts, they think I'm an outlier or they think I'm an
2 old fuddy-duddy, there's something wrong with me. They
3 don't believe me.

4 "Because the truth is that trans is normal,
5 you see, and -- and that they can have highly 05:06:33
6 successful lives, just like anybody else.

7 "And it's not based on experience. It's
8 certainly not based on any scientific scrutiny, you
9 see.

10 "And so what I'm really saying is that so many 05:06:46
11 of the doctors just practice how they've been taught to
12 practice. They -- they -- we -- we -- none of us have
13 the brain power -- we take care of so many different
14 things, we can't be experts in -- in -- in the original
15 train of -- that chain of trust at all, you see. 05:07:05

16 "So of course we oversimplify everything.

17 "And, you know, there -- we rely on -- on a
18 few skeptics like -- like the three of us."

19 BY MS. HARTNETT:

20 Q Dr. Levine, was that clip of you speaking on 05:07:22
21 the podcast earlier this year?

22 A It is.

23 Q Was that your truthful statements?

24 MR. TRYON: Objection.

25 ///

1 BY MS. HARTNETT:

2 Q Sorry?

3 A I said --

4 Q I --

5 A -- those things that you heard on the podcast, 05:07:44
6 yes.

7 Q And were they your truthful statements?

8 A Yes.

9 MS. HARTNETT: Okay. Could you play
10 Exhibit 94, please. 05:07:53

11 (Exhibit 94 was marked for identification
12 by the court reporter and is attached hereto.)

13 (Video Clip Played.)

14 "And then three years later, there was the six
15 standards of care that was almost word for word for 05:07:59
16 what our group did except for one letter was necessary.
17 That is, he wanted to make it easier to get
18 transgender."

19 BY MS. HARTNETT:

20 Q Dr. Levine, was that you speaking on the 05:08:15
21 podcast earlier this year?

22 A Yes. And it's my truthful statement.

23 Q Thank you. You used the term "get
24 transgender" on that clip. I was just wondering what
25 you mean by that. 05:08:27

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1 A I think that was referring to hormones, access
2 to hormones.

3 We used to have a standard that two
4 independent individuals or one group committee were
5 required to write a recommendation for hormones, and 05:08:44
6 Dr. Richard Green, who was the head of the organization
7 at the time, didn't like that at all. He was a strong
8 advocate of immediate care. And he told me so, he
9 didn't like it. And -- and he reconstituted --
10 accepted the fifth standards of care, and he formed a 05:09:05
11 new committee with the -- you know, with the charge to
12 get rid of that criteria for hormones.

13 Q Do you typically use the term "get
14 transgender"?

15 A No. This was a spontaneous conversation. I 05:09:24
16 don't -- it's a funny phrase. I don't know. It came
17 out of my mouth. I don't know why. That's --

18 Q Okay.

19 A -- not my usual language.

20 But again, this was not a paper I was 05:09:33
21 delivering that I, you know, worked on. This is
22 something that happened rather spontaneously.

23 Q I understand.

24 MS. HARTNETT: Could you please play
25 Exhibit 95. 05:09:49

1 (Exhibit 95 was marked for identification
2 by the court reporter and is attached hereto.)
3 (Video Clip Played.)
4 "I think it's time for a re-examination of the
5 wisdom of affirmative care. I'm not saying affirmative 05:09:55
6 care doesn't help some people, but I'm not so sure how
7 many people it harms."
8 BY MS. HARTNETT:
9 Q Dr. Levine, was that your truthful statement
10 on the podcast earlier this year? 05:10:09
11 A It --
12 MR. TRYON: Same objection as before.
13 Thank you.
14 You may answer.
15 THE WITNESS: I -- it is my true statement. 05:10:18
16 I'm still not sure what percentage of people
17 are ultimately harmed and how to measure those harms
18 and when to measure those harms.
19 MS. HARTNETT: Thank you.
20 Could you play tab -- sorry -- Exhibit 96, 05:10:33
21 please.
22 (Exhibit 96 was marked for identification
23 by the court reporter and is attached hereto.)
24 (Video Clip Played.)
25 "The problem is that we do not have rigorous 05:10:38

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1 follow-up studies of people who made the transition."

2 BY MS. HARTNETT:

3 Q Dr. Levine, is that your truthful statement
4 made earlier this year?

5 MR. TRYON: Objection. 05:11:00

6 THE WITNESS: Yes.

7 MR. TRYON: I just want to place on the record
8 evidence rule 106. Thank you.

9 Go ahead and answer.

10 BY MS. HARTNETT: 05:11:05

11 Q Dr. Levine, do you agree that there is not
12 rigorous follow-up studies of people who have made the
13 transition?

14 A Yes. I believe I testimony -- I testified to
15 that earlier today. 05:11:24

16 Q And for all of these statements that I've
17 asked you about, do you stand by those statements,
18 sitting here today?

19 A Number one, I have said those things, and I
20 believe them to be essentially correct today, yes. 05:11:36

21 Q And, thank you, I'm asking only to -- in light
22 of the objection, not to repeat my questions to you.

23 MS. HARTNETT: Could you please play
24 Exhibit 97.

25 (Exhibit 97 was marked for identification 05:11:48

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1 by the court reporter and is attached hereto.)

2 (Video Clip Played.)

3 "The people who come to me who are depressed,
4 you know, those -- those -- after transition, those are

5 just anecdotal reports. I have no idea what the -- 05:12:00
6 what the denominator is, you see."

7 BY MS. HARTNETT:

8 Q Dr. Levine, do you agree with the statement
9 that was just played?

10 A Yes. 05:12:10

11 MS. HARTNETT: Could you please play
12 Exhibit 98.

13 (Exhibit 98 was marked for identification
14 by the court reporter and is attached hereto.)

15 MR. TRYON: Counsel, before you play it -- 05:12:19

16 MS. HARTNETT: Yes.

17 MR. TRYON: Counsel, will you just agree to
18 give me a standing objection to these excerpts?

19 MS. HARTNETT: Yes.

20 MR. TRYON: Thank you. 05:12:28

21 (Video Clip Played.)

22 "And -- and because we don't know, because we
23 don't know, I think we have to say why do we have all
24 this enthusiasm, why do we have all this chain of trust
25 passion that this is the best treatment. We don't know 05:12:46

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1 is the best treatment, you see."

2 BY MS. HARTNETT:

3 Q Dr. Levine, do you agree with that statement
4 that you made earlier this year?

5 A I do. 05:12:58

6 MS. HARTNETT: Could you please play
7 Exhibit 99.

8 (Exhibit 99 was marked for identification
9 by the court reporter and is attached hereto.)

10 (Video Clip Played.) 05:13:05

11 "Now, I want to quickly say that while I'm an
12 advocate of someone who thinks or wants to be or
13 considers themselves a transgendered person, I think
14 they ought to have a psychotherapeutic approach before
15 they make any -- any life-changing decisions, but I 05:13:22

16 admit that I have no follow-up. This is not on the
17 basis of randomized control study. I am in the same
18 difficult position that the affirmative care doctors
19 are in, only I have more faith based upon a hundred
20 years of doing psychotherapy as a tradition, you see, 05:13:42
21 and they only have a few years, with no follow-up."

22 BY MS. HARTNETT:

23 Q Dr. Levine, is that your truthful statement?

24 A Yes.

25 MS. HARTNETT: Could you please play 05:14:02

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1 Exhibit 100.

2 (Exhibit 100 was marked for identification
3 by the court reporter and is attached hereto.)

4 (Video Clip Played.)

5 "So -- so what I'm saying is that in the early 05:14:05
6 studies, the death rates from cancer and cardiovascular
7 disease and -- and accidents were -- were elevated and
8 what -- and what that really means is that the
9 lifestyle things predispose them to physical diseases.

10 "So, you know, if you're a parent, you -- 05:14:27
11 you -- you want to die -- you want to die before your
12 children, you see.

13 "So for many -- for many of these kids,
14 they're going to be sick.

15 "And I just saw a slide of the famous -- 05:14:41
16 Jazz Jennings. Do you know that name?

17 Female: Yeah.

18 "Apparently Jazz Jennings was a very thin,
19 very attractive person when she had surgery, and in the
20 postoperative time, she's now grossly obese. She is -- 05:14:58
21 I saw a picture of her. She is grossly obese.

22 "So, you know, this is one of the -- this is
23 one of the things that never gets talked about, what
24 are the physical manifestations, what are the
25 psychological manifestations, what are the outcomes." 05:15:13

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1 BY MS. HARTNETT:

2 Q Dr. Levine, is that your truthful statement?

3 A Yes.

4 Q Is it your contention that Jazz Jennings is
5 grossly obese because she had gender confirmation 05:15:29
6 surgery?

7 A No. She became grossly obese after gender
8 confirmation surgery. In addition, she had -- she had
9 other problems as well, I think.

10 I only know that because Jazz Jennings is a 05:15:50
11 public, you know, celebrity, so to speak, and people
12 talk about her and people showed me pictures of her.

13 So I've never -- that's -- that's what I know.

14 Q But you've never met Jazz Jennings; correct?

15 A I have never met Jazz Jennings. 05:16:09

16 MS. HARTNETT: Could you play Exhibit 101,
17 please.

18 (Exhibit 101 was marked for identification
19 by the court reporter and is attached hereto.)

20 (Video Clip Played.) 05:16:19

21 "And the -- the affirmative care doctors like
22 to blame all these comorbidities and the shortened
23 lifespan on minority stress, and you would -- I
24 think -- I think we recognize that it is stressful to
25 be -- to belong to a sexual minority, but -- but 05:16:32

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1 children who are cross-gender identified, who have
2 separation anxiety and depression and so forth, they're
3 not -- they're not having minority stress.

4 "And -- and the kids who -- you know, if
5 you -- if you walk in -- if you walk in and see your 05:16:50
6 postpartum depressed mom hanging from the rafters and
7 then you decide three weeks later that you're going to
8 change your gender, this is not minority stress."

9 BY MS. HARTNETT:

10 Q Dr. Levine, is that your truthful statement? 05:17:07

11 A Yes.

12 Q Are you aware of any example of an actual kid
13 who walked in and saw their postpartum depressed mom
14 hanging from the rafters and three weeks later decided
15 to change gender? 05:17:22

16 A Absolutely.

17 Q Can you tell me what -- where is that example?

18 A I think that case was presented to me.

19 Q By whom?

20 A One of my staff. Or it was presented to me, 05:17:33
21 you know, by somebody else.

22 Occasionally, I supervise other people.

23 But that came -- that -- that came from a
24 recent -- a recent January 20th case history that I
25 heard. 05:17:53

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1 It -- it has to do, you see, with not taking a
2 history, giving people, very quickly, affirmative care
3 and not appreciating the forces that might have shaped
4 this -- that -- that may be very -- that may play out
5 and may -- very difficult to have a happy, successful 05:18:15
6 life as a trans person.

7 So I -- I can't give you the -- I can't tell
8 you at the moment who told me that, but I can tell you
9 I am not telling -- I am telling the truth. This is
10 what I recently heard prior -- 05:18:34

11 Q Was that as a -- sorry.

12 A Pardon me.

13 Q Was that -- was that an anecdote that came to
14 you from somebody in your clinic?

15 A As I said before, it might have been someone 05:18:43
16 in my clinic; it might have been some other
17 professional who talked to me about that.

18 Q Do you know if the person at issue, the --
19 the -- that was seeking a transition, whether they had
20 any signs of gender dysphoria prior to the mom hanging 05:18:58
21 from the rafters?

22 A I think the implication was that they hadn't,
23 but I don't remember enough details to -- I couldn't
24 tell you the case history. That's the aspect of the
25 case history that I recall. 05:19:18

1 Q Thank you.

2 MS. HARTNETT: Can you play Exhibit 102,
3 please.

4 (Exhibit 102 was marked for identification
5 by the court reporter and is attached hereto.) 05:19:26

6 (Video Clip Played.)

7 "Lots of girls have temporary eating
8 disorders, and some of them end up overcoming it, but
9 they overcome it sometimes by becoming vegetarians or
10 vegans. So it's okay, and it's much better. It's much 05:19:42
11 better than having an eating disorder."

12 BY MS. HARTNETT:

13 Q Dr. Levine, was that your truthful statement?

14 A Yes.

15 Q What point were you trying to make by drawing 05:19:59
16 an analogy to eating disorders and vegetarians and
17 vegans?

18 A I think you would have to play for me what
19 preceded that, but off the top of my head today, two
20 months after I made that statement, more than two 05:20:14
21 months after I made that statement, I was probably
22 making reference to the fact that among adolescent
23 girls who declare themselves to be trans boys, a large
24 percentage of them have a pre- -- a predeclaration
25 eating disorder, that this is part of the -- the 05:20:35

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1 psycho- -- the -- if we can agree that an eating
2 disorder is a true problem and not just a dietary of
3 something or other, the -- this evidence of the
4 psychopathology that precedes transgender
5 identification, the crystallization of a trans 05:20:59
6 identification, eating disorder is just another way of
7 self-harm where -- where one cannot live comfortably in
8 the self as it is developing.

9 So that's probably what I was making reference
10 to, the pre-crystallization of a transgender, the 05:21:18
11 problems that are some- -- that are often seen in girls
12 prior to their coming out as a trans boy.

13 Q Is it your view that you could correct the
14 eating disorder and the person may stop identifying as
15 transgender? 05:21:38

16 A Well, I think most eating dis- -- what I was
17 saying -- I think you misunderstood -- is the -- the
18 prelude to the eating disorder was transgender. I will
19 say if you could help the person understand the
20 motivation for the eating disorder and help her to come 05:22:00
21 to grips with what she's doing is harmful to herself in
22 the short and in the long run, then it wouldn't -- it
23 may prevent -- it may help her to find another
24 solution, for example, becoming a vegan or -- that
25 would be a benign -- a less -- less problematic 05:22:25

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1 solution than having to become transgender, forget her
2 eating disorder and focus on something else in a way
3 that dominates her life.

4 So you -- you dominate your life by thinking
5 that you're too fat when you're 93 pounds, and now 05:22:43
6 you're domi- -- you give that up, and then you dominate
7 your life because you're really a boy trapped in a
8 girl's body and --

9 So I'm telling you, as a psychiatrist, life is
10 complicated and histories are complicated and our 05:22:57
11 ability to predict things is not very good, and I just
12 want us to rely on science, as -- whatever the
13 limitations of sciences are, I want to rely on science
14 and not something shorter than science, you know,
15 fervent, passionate beliefs, whatever. 05:23:19

16 Q So in that instance -- I'm just trying to make
17 sure I understand -- your -- the idea would be that
18 it's better to end up being vegan than transgender?

19 A If -- if you put it in that way, if you reduce
20 everything to that simplicity, I guess the answer is it 05:23:35
21 would be better to have a -- that would be a better
22 supplementation of your original concerns about
23 yourself and your body and the sexual meaning of your
24 body than it is to repudiate your femininity entirely
25 and try to remove your breasts surgically and take 05:23:56

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1 hormones and so forth, yes.

2 MS. HARTNETT: Could you play Exhibit 103,
3 please.

4 (Exhibit 103 was marked for identification
5 by the court reporter and is attached hereto.) 05:24:04

6 (Video Clip Played.)

7 "It's your current sexual identity --

8 Female: Yeah.

9 -- "you see. I mean, I'm sure I've had
10 identities -- I used to be a stamp collector, you know. 05:24:15
11 I had an identity as a stamp collector. And I don't
12 collect stamps anymore."

13 BY MS. HARTNETT:

14 Q Dr. Levine, are those your truthful
15 statements? 05:24:28

16 A I was a stamp collector.

17 Q I was a baseball card collector.

18 Is being transgender like being a stamp
19 collector?

20 A No. 05:24:38

21 MS. HARTNETT: Could you play tab --
22 Exhibit 104, please.

23 (Exhibit 104 was marked for identification
24 by the court reporter and is attached hereto.)

25 (Video Clip Played.) 05:24:55

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1 "I think the doctor's responsibility is to
2 diagnose this, understand the factors that is pushing
3 the child in that direction and the family in that
4 direction and to inform what -- the parents and the
5 child of what is known and what is not known and what 05:25:10
6 the alternative treatments are, and the parents and the
7 child make the decision, not the doctor. The doctor
8 does not have the data to make the decision."

9 BY MS. HARTNETT:

10 Q Dr. Levine, is that your truthful statements? 05:25:28

11 A That is, although I'm embarrassed, but I used
12 the wrong -- I should have said "are" and not "is" in
13 the first sentence.

14 Q I think I just did the same thing.

15 I have one more excerpt to play. 05:25:42

16 MS. HARTNETT: Could you play Exhibit 105,
17 please.

18 (Exhibit 105 was marked for identification
19 by the court reporter and is attached hereto.)

20 (Video Clip Played.) 05:25:48

21 "So if I'm an expert in something, it's a very
22 narrow topic I'm an expert in. Even though I'm a
23 doctor and you -- somebody may think, well, he's a
24 doctor; right? But the doctor doesn't know much about
25 most things. 05:26:01

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1 "And -- and there is the wisdom, I think, is
2 the difference between demagoguery, which I think many
3 affirmative care doctors are demagogues, and experts,
4 many of whom are just uneasy about what is not known."

5 BY MS. HARTNETT:

05:26:23

6 Q Dr. Levine, were these your truthful
7 statements from earlier this year?

8 A Yes.

9 Q Do you consider yourself to be a demagogue or
10 an expert?

05:26:36

11 A I consider myself, on this issue of the
12 scientific basis of -- of trans delivery -- care
13 delivery, to be an expert in this very narrow field
14 because my definition of an expert, knows the
15 difference between what is known and what is not known,
16 you see.

05:26:53

17 On many subjects that I have to work on every
18 day as a psychiatrist, I -- I have -- I -- I'm not sure
19 what -- the difference between what I know and what is
20 known by more expert people in the field.

05:27:10

21 I seem to have enough to have credentials as a
22 practicing doctor, but I'm not an expert in most things
23 I take care of.

24 When it comes to the data about this matter of
25 trans care, I feel I'm a relative expert, and I think I

05:27:28

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1 have more perspective and more basis for that
2 perspective than many people who have been taught how
3 to take care of transgender people.

4 Q Do you believe Dr. Adkins is a demagogue?

5 A I don't know Dr. Adkins well enough to -- to 05:27:49
6 make that decision. I don't want to be insulting at
7 all to my colleagues, but if -- if Dr. Adkins believes
8 this is genetically determined and if she believes that
9 it's fixed and if she believes she's helping and she
10 has evidence that she's helping people live happy lives 05:28:11
11 for the next 40 years, I believe she is much more
12 closer to my definition of a demagogue than, say, a
13 person who can't distinguish between what she knows and
14 what is known versus an expert.

15 But I don't want to pass judgment on her 05:28:27
16 because, you know, I've just read her report, that's
17 all.

18 Q How about Dr. Safer, would you have the same
19 view there, that -- do you believe he's a demagogue, or
20 you wouldn't want to pass judgment? 05:28:39

21 A You know, one of the ethical principles of
22 being a doctor is to speak respectfully of one's
23 colleagues.

24 I -- I would say, I just want to repeat, that
25 most practicing doctors have a belief system that 05:28:58

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1 they're working on the side of angels, and that's a
2 different set of ideas than what science has already
3 demonstrated.

4 So to the extent that people believe,
5 passionately believe, that what they are doing is 05:29:10
6 ensuring a -- a -- a productive, successful,
7 asymptomatic, fulfilling life and there's no evidence
8 for it, well, I think they're not -- they shouldn't be
9 certain about that.

10 And they're closer to an ordinary physician or 05:29:30
11 a demagogue than they are to an expert.

12 Q Thank you. Could you just -- I have a --
13 hopefully, a couple of final questions about your
14 expert report.

15 Could you pull that back up? That was 05:29:44
16 Exhibit 87.

17 MR. BROOKS: Coming, coming.

18 BY MS. HARTNETT:

19 Q And I'm going to be just going to
20 paragraph 81. 05:29:54

21 MR. BROOKS: Which is on.

22 MS. HARTNETT: It's on -- take your time, but
23 page 31, paragraph 81.

24 MR. BROOKS: What heading are we under here?

25 MS. HARTNETT: You are under -- 05:30:10

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1 MR. BROOKS: I see it. I see the heading at
2 the top of page 30.

3 Is that the right heading? Am I missing
4 anything --

5 MS. HARTNETT: Correct. 05:30:23

6 MR. BROOKS: -- or is that --

7 Under "Opinions and practices vary widely..."
8 Okay.

9 And then you said paragraph 81?

10 MS. HARTNETT: Right. And this is a paragraph 05:30:29
11 about -- Dr. Levine is describing a Lichenstein
12 article; is that correct?

13 MR. BROOKS: Let me just say, Dr. Levine, if
14 you want to look at any paragraphs between the heading
15 and this one, for context, you should feel free to, or 05:30:46
16 if not -- if you don't feel the need, then you don't
17 need to.

18 THE WITNESS: Okay.

19 BY MS. HARTNETT:

20 Q So this paragraph is talking about, in your 05:31:09
21 words, the "loose standards" at Dr. Safer's clinics at
22 Mount Sinai in Columbia; correct?

23 A Yes.

24 Q And do you say that he's -- I'm just reading
25 from the first sentence, but you a say at least one 05:31:22

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1 prominent clinic, quote, is quite openly admitting
2 patients for even surgical transition who are not
3 eligible under the criteria set out in WPATH's
4 Standards of Care.

5 Do you see that? 05:31:36

6 A Yes. The last sentence, right.

7 Q Is it your understanding that patients were
8 receiving care there without meeting the WPATH
9 standards?

10 A WPATH standards are just one set of standards, 05:31:53
11 and I guess Dr. Safer has a different set of standards.

12 I don't think that WPATH needs to be followed,
13 you know. I don't think they're -- they are in fact
14 the standards of care. They are just an organization
15 that is providing some guidelines, which they call 05:32:19
16 standards of care, but aren't true standards of care.
17 They're just guidelines from a professional
18 organization that is -- that is an advocacy
19 organization for -- for the treatment -- for
20 affirmative treatment. 05:32:36

21 Q But are you aware that Mount Sinai went
22 through the process of having those people satisfy the
23 WPATH standards before they had surgery notwithstanding
24 that they would have also met the other standards set
25 forth by Sinai? 05:32:47

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1 MR. BROOKS: Objection.

2 THE WITNESS: I'm -- I'm not deeply involved
3 in the process of how Dr. Safer has done his work.
4 This would be not an area of my expertise about --
5 about his criteria. 05:33:04

6 BY MS. HARTNETT:

7 Q I guess my question for you is whether you
8 know, sitting here today, whether in fact Dr. Safer's
9 center allowed patients to have surgery under what you
10 call the "loose standards" without satisfying WPATH. 05:33:17

11 A Well, it was my understanding from the quoted
12 study that -- that he was providing -- or giving
13 permission for surgical care for people who may not
14 have met the few criteria that -- that we have -- had
15 organized in 2000- -- in, you know, the seventh 05:33:44
16 edition.

17 Q Did you read the Lichtenstein article before
18 citing it here?

19 A I must have read it, but it's probably one of
20 hundreds of articles, and right now, I can't recall the 05:33:54
21 details.

22 Q Thank you.

23 MS. HARTNETT: Could I take a -- go off -- I
24 think I'm almost -- or -- done, if not done.

25 But could we go off the record briefly for me 05:34:06

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1 to collect my nets and then hopefully we'll be done?

2 THE VIDEOGRAPHER: We are off the record at

3 5:34 p.m.

4 (Recess.)

5 THE VIDEOGRAPHER: We are on the record at 05:44:53

6 5:45 p.m.

7 MS. HARTNETT: Thank you, Dr. Levine. I have

8 no further questions, but reserve the right to any

9 recross if there's further questioning of you.

10 THE WITNESS: You're welcome. 05:45:12

11 MS. HARTNETT: Thank you.

12 MR. BROOKS: Speaking for the -- Roger Brooks,

13 speaking for the intervenor, I have no questions for

14 the witness.

15 MR. TRYON: This is Dave Tryon on behalf of 05:45:20

16 the State of West Virginia.

17 Dr. Levine, thank you for your time.

18 I have no questions.

19 MS. MORGAN: This is Kelly Morgan on behalf of

20 the West Virginia Board of Education and Superintendent 05:45:29

21 Burch. I have no questions. Thank you.

22 MS. DENIKER: Dr. Levine, this is Susan

23 Deniker, counsel for defendants Harrison County Board

24 of Education and Superintendent Stutler, and I have no

25 questions for you.

1 Thank you for your time.

2 THE WITNESS: You're welcome.

3 MS. ROGERS: Dr. Levine, this is Shannon
4 Rogers on behalf of the West Virginia Secondary School
5 Activities Commission. I have no questions either. 05:45:53

6 Thank you.

7 THE WITNESS: You're welcome.

8 MS. HARTNETT: Dr. Levine, thank you for your
9 time.

10 THE VIDEOGRAPHER: Thank you. 05:46:00

11 We are off the record at 5:46 p.m., and this
12 concludes today's testimony given by Stephen Levine,
13 Dr. -- Dr. Stephen Levine.

14 The total number of media units was seven and
15 will be retained by Veritext Legal Solutions. 05:46:16

16 Thank you.

17 (TIME NOTED: 5:46 p.m.)

18

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2
3
4 I, STEPHEN LEVINE, do hereby declare under
5 penalty of perjury that I have read the foregoing
6 transcript; that I have made any corrections as appear
7 noted, in ink, initialed by me, or attached hereto;
8 that my testimony as contained herein, as corrected, is
9 true and correct.

10 EXECUTED this ____ day of _____,
11 20____, at _____, _____.
(City) (State)

12
13
14
15 _____
STEPHEN LEVINE

16 VOLUME I
17
18
19
20
21
22
23
24
25


1 I, the undersigned, a Certified Shorthand
2 Reporter of the State of California, do hereby certify:

3 That the foregoing proceedings were taken
4 before me at the time and place herein set forth; that
5 any witnesses in the foregoing proceedings, prior to
6 testifying, were placed under oath; that a record of
7 the proceedings was made by me using machine shorthand
8 which was thereafter transcribed under my direction;
9 further, that the foregoing is an accurate
10 transcription thereof.

11 I further certify that I am neither financially
12 interested in the action nor a relative or employee of
13 any attorney of any of the parties.

14 IN WITNESS WHEREOF, I have this date subscribed
15 my name.

16
17 Dated: April 15, 2022

18
19 
20

ALEXIS KAGAY

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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